

## 13862, CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. LENGTH OF STAY IN 1b <b>?</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4835 Langdrum Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>F.</b> Last <b>Aldridge</b>				4. DATE OF DEATH Month <b>December</b> Day <b>12,</b> Year <b>19 59</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/26/1892</b>	
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Lithographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>			
11. BIRTHPLACE (State or foreign country) <b>Conn.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Thomas Aldridge</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Brooks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>wife</b>				Address <b>Chevy Chase, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <b>8 1/2 years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1946</b> , 19____, to <b>12/12</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12/6</b> , 19 <b>59</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1212 1/2 St. N.W., Washington D.C.</b>							
ACTUAL SIGNATURE <i>John H. Schumacher</i>				M.D. <b>1212 1/2 St. N.W., Washington D.C.</b>			
PHYSICIAN'S NAME (Type) <b>John H. Schumacher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1944  
 12/12/44  
 12/12/44  
 12/12/44

Coronary Thrombosis  
 Atherosclerotic Heart Disease

George Thomas Alderson  
 12/12/44  
 12/12/44  
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12/12/44  
 12/12/44  
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12/12/44  
 12/12/44  
 12/12/44

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13858

## CERTIFICATE OF DEATH

13797

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS REST HOME</b>		d. STREET ADDRESS <b>7701 GEORGIA AVENUE, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>RICHBELL</b> Last <b>ALLABAND</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>11</b> Year <b>59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/72</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Druggist</b>	9. AGE (In years last birthday) <b>87</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM R. ALLABAND</b>		14. MOTHER'S MAIDEN NAME <b>MARY KINNEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-24-8593</b>	
17. INFORMANT <b>Mrs. Emma C. Allaband, 7701 Ga. Ave., N.W.</b>		Address <b>Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 26</b> , 19 <b>59</b> , to <b>December 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>December 9</b> , 19 <b>59</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Coleman M.D.</b>		ADDRESS (Street, city or town, state) <b>733 Sigo Avenue Silver Spring Md.</b>	
PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN</b>		DATE SIGNED <b>12/11/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13798

Reg. Dist. No.

13864

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>1 yr., 2 mos.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARILEA NURSING HOME</b>		d. STREET ADDRESS <b>8819 Second Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JERUSHA</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/80</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert L. Nash</b>	
14. MOTHER'S MAIDEN NAME <b>Susan Poor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Geo. H. Manning, 8819 2nd Ave., Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 58</b> to <b>27 Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 Dec</b> , 19 <b>59</b> , and that death occurred at <b>8:30 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b>		ADDRESS (Street, city or town, state) <b>7006 Glenville Rd Silver Spring Md</b> DATE SIGNED <b>12/27/59</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/30/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond H. Jaska</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# 13865 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

13799

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Virginia</u> b. COUNTY <u>Norfolk</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>THEODORE</u> Middle <u>ROOSEVELT</u> Last <u>ARTIS, JR.</u>				<b>4. DATE OF DEATH</b> Month <u>DECEMBER</u> Day <u>10</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>December 6, 1945</u>	
<b>9. AGE</b> (In years last birthday) <u>14</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Theodore R. Artis, Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Bessie Gray</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>The Medical Record</u>		<b>Address</b> <u>The Clinical Center, Bethesda 14, Maryland</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Lungs, Post Operative</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atrioventricular Canal</u> DUE TO (c) <u>Mitral Insufficiency</u>	
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hours</u>		<b>20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		<b>21. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>22. MEDICAL CERTIFICATION</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. 19 p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>November 15, 19 59</u> , to <u>December 10, 19 59</u> , that I last saw the deceased alive on <u>December 10, 19 59</u> , and that death occurred at <u>4:12 P.M.</u> from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Roland Folse, M.D.</u>				<b>DATE SIGNED</b> <u>12-11-59</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>ROLAND FOLSE, M.D.</u>				<b>ADDRESS</b> <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>12-11-59</u>		<b>22b. DATE THEREOF</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b>		<b>22d. LOCATION</b> (City, town, or county) <u>Norfolk</u> (State) <u>Va.</u>	
<b>23. FUNERAL-DIRECTOR'S SIGNATURE</b> <u>Frazier Funeral Home Inc.</u>				<b>ADDRESS</b> <u>384-R.D. Ave. N.W.</u> <u>N.O.C.</u>			
<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>DATE</b> <u>DEC 14 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BOSTON

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. DATE OF DEATH [Faint text]</p>	
<p>13. PLACE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. SIGNATURE OF WITNESS [Faint text]</p>		<p>16. DATE OF CERTIFICATE [Faint text]</p>	

13866

CERTIFICATE OF DEATH

13800

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>162 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>7219 Spruce Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Patricia</b> Middle <b>Elaine</b> Last <b>Atler</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 January 1952</b>	9. AGE (In years last birthday) <b>7</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry D. Atler, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Barnett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wilms's Tumor with extensive involvement of lungs,</b> DUE TO <b>liver and pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22, 1959</b> , to <b>December 1, 1959</b> , that I last saw the deceased alive on <b>December 1, 1959</b> , and that death occurred at <b>1:25 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Arthur R. Rothman</b>		M.D. <b>The Clinical Center</b>		<b>12/1/59</b>			
PHYSICIAN'S NAME (Type) <b>Arthur R. Rothman</b>		M.D. <b>National Institutes of Health</b>		<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec 4, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll St NW DC</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1952

11

Decedent's Name: James H. White  
Age: 102 days  
Sex: Male  
Race: White  
Date of Birth: 29 January 1952  
Place of Birth: Washington, D. C.  
Usual Residence: Washington, D. C.  
Cause of Death: Infantile  
Manner of Death: Natural

Signature of Physician: James H. White, Jr.  
Signature of Medical Examiner: James H. White, Jr.  
Signature of Coroner: James H. White, Jr.  
Signature of Registrar: James H. White, Jr.  
Signature of Burial Director: James H. White, Jr.

Place of Burial: Washington, D. C.  
Date of Burial: 29 January 1952  
Burial Director: James H. White, Jr.

The Medical Examiner: James H. White, Jr.  
The Coroner: James H. White, Jr.  
The Registrar: James H. White, Jr.  
The Burial Director: James H. White, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13867

13801

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83X-3</b> d. STREET ADDRESS <b>1601 East Lee Highway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph George Jr. BARNA</b>				4. DATE OF DEATH Month Day Year <b>December 1 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-59</b>	9. AGE (In years last birthday) <b>— yrs.</b>	IF UNDER 1 YEAR Months Days <b>12</b>	IF UNDER 24 HRS. Hours Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph George Barna Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Jacqueline OSTRANDER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(Father) Joseph G. Barna Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.5 Intestinal obstruction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>570.5</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>26 November, 19 59</b> to <b>1 December, 1959</b> , that I last saw the deceased alive on <b>1 December, 19 59</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.D. HOOVER</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 12-2-59</b>					
PHYSICIAN'S NAME (Type) <b>W.D. HOOVER LT MC USN</b>		U.S. Naval Hospital, NNMC, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>1557 Wisconsin Ave. Bethesda Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

2051212XV3

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Barnes (A. M.)

2 Dec

1938

U.S. Naval Hospital, Bethesda, Md.

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Joseph

George W. Davis

1938

December 1

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Joseph George Davis, Jr.

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(To Mary) Joseph G. Davis

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

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1938

U.S. Naval Hospital, Bethesda, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13802

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R-1</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Redland</u>				d. STREET ADDRESS <u>Redland</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Virgil Clark Barnhouse</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec 25 - 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 22 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Ernest C. Barnhouse</u>			
14. MOTHER'S MAIDEN NAME <u>Mary C. Copper</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>577-16-9748</u>				17. INFORMANT <u>Esther May Barnhouse (wife)</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12-25-59</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville Meth. Cem.</u>			
22d. LOCATION (City, town, or county) <u>Laytonsville, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>			ADDRESS <u>Laytonsville, Md.</u>				
24a. REC'D BY REGISTRAR <u>DEC 31 59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Throckmorton</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
				</																									



1

13826

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13803

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park Md.</b> c. LENGTH OF STAY IN 1b <b>3 Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shannon Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WASH</b> b. COUNTY <b>D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> d. STREET ADDRESS <b>949 Longfellow St, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace Virginia Beard.</b>		4. DATE OF DEATH Month <b>12/</b> Day <b>5/</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Leesburg Va.</b>
13. FATHER'S NAME <b>Gheen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Bertie M Caffrey,</b> Address <b>949 Longfellow St N.W.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Cardiac Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>1956</b> to <b>5 DEC 1959</b> , that I last saw the deceased alive on <b>4 Dec 1959</b> , and that death occurred at <b>5:06 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William B. Lind</b>		ADDRESS (Street, city or town, state) <b>9006 Collesville Rd</b> DATE SIGNED <b>12/5/59</b>	
PHYSICIAN'S NAME (Type) <b>Salmer Spang M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pr Georges Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. K. Huntman &amp; Son</b>		24a. REC'D BY REGISTRAR <b>DATE DEC 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15 1877		Baltimore, Md.	
MARRIED		Single		Widow		Divorced		Never married	
Usual Residence		Place of Death		Cause of Death		Manner of Death		Occupation	
Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		None	
Physician		Funeral Home		Burial Place		Date of Burial		Name of Minister	
Dr. J. H. Harris		J. H. Harris		St. James Church		Jan 20 1922		Rev. J. H. Harris	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Hour of Death		Minute of Death		Second of Death	
Jan 18 1922		10:00 AM		10:00		00		00	
Place of Death		Cause of Death		Manner of Death		Occupation		Signature of Registrar	
Baltimore, Md.		Heart Disease		Natural		None		[Signature]	
Physician		Funeral Home		Burial Place		Date of Burial		Name of Minister	
Dr. J. H. Harris		J. H. Harris		St. James Church		Jan 20 1922		Rev. J. H. Harris	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Burial Officer		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Hour of Death		Minute of Death		Second of Death	
Jan 18 1922		10:00 AM		10:00		00		00	
Place of Death		Cause of Death		Manner of Death		Occupation		Signature of Registrar	
Baltimore, Md.		Heart Disease		Natural		None		[Signature]	

RECEIVED  
JAN 20 1922  
BALTIMORE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13804

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg - R-2</u> c. LENGTH OF STAY IN TB <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Emory Grove</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-2</u> d. STREET ADDRESS <u>Emory Grove</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Arthur Roosevelt Beale Jr</u> First Middle Last				<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>25</u> Year <u>1959</u>				
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 24, 1959</u>		<b>9. AGE</b> (In years last birthday) <u>19</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> <b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) _____			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>	
<b>13. FATHER'S NAME</b> <u>Arthur R. Beale</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Neal</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Mary Beale (mother)</u>		Address <u>Stem 2</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO _____ (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a. m. _____ p. m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>12-25-59</u>				
<b>22a. BURIAL, CREMATION, REBURY</b> (Specify) <u>Buried</u>		<b>22b. DATE THEREOF</b> <u>12/27/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Emory Grove.,</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Emory Grove, Md.</u> (State) _____		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u>				<b>ADDRESS</b> <u>Rockville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>DEC 29 '59</u>		
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton L. Kline</u>				_____				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF BALTIMORE DISTRICT OF BALTIMORE		NAME OF DECEASED _____	
SEX OF DECEASED _____		AGE OF DECEASED _____	
DATE OF DEATH _____		PLACE OF DEATH _____	
OCCASION OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		PREVIOUS ILLNESS _____	
TREATMENT _____		MEDICATIONS _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

BALTIMORE  
 DEPARTMENT OF HEALTH  
 MEDICAL EXAMINER

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF BALTIMORE.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**13827** **CERTIFICATE OF DEATH**

Reg. Dist. No.

13805

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DC</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL (If patient in hospital, give street address) OR INSTITUTION <b>517 Albany Avenue Oak Haven Rest Home</b>		d. STREET ADDRESS <b>1920 Park Road, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Bode</b>		4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months <b></b> Days <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Kaltenbach</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmenia Hockenheimer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Oak Haven Rest Home-517 Albany Avenue Takoma Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, lobar.</b> DUE TO <b>Cardio vascular decompensation &amp; arteriosclerosis</b> (c) <b>1 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Age</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>2 days.</b> <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July</b> , 19 <b>52</b> , to <b>Dec 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/2/59</b> , 19 <b>59</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b>		ADDRESS (Street, city or town, state) <b>4301 48th St. N.W.</b> DATE SIGNED <b>12/3/59</b>	
PHYSICIAN'S NAME (Type) <b>S. A. Thomas MD</b>		<b>Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>12/5/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.-2901 14th St. N.W. Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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CERTIFICATE OF DEATH

13851

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Non-Resident

Laurel Park

1415 1/2 1st Avenue  
Oak Haven, N.Y.

1415 1/2 1st Ave., N.Y.

Male

11/1/1895

Ohio

Wilhelmina Hoffmann

1415 1/2 1st Avenue  
Oak Haven, N.Y.

John Hoffmann

1415 1/2 1st Avenue

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## CERTIFICATE OF DEATH

Reg. Dist. No.

13870

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS</u>				d. STREET ADDRESS <u>1502 DOMER AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>FREDERICK</u> Last <u>BOETTCHER</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-72</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MUSICIAN 45 MARINE BAND Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash DC</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jachim Boettcher</u>				14. MOTHER'S MAIDEN NAME <u>Mary Engle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII 1937</u>				16. SOCIAL SECURITY NO. <u>-</u>		INFORMANT Address <u>Albert &amp; Altemus 502 Domer Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion.</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>?</u> <u>2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, amputated both legs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Dec 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 9</u> , 19 <u>59</u> , and that death occurred at <u>12:10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6300 43rd St, NW, Wash. D.C.</u> DATE SIGNED <u>12/14/59</u>							
ACTUAL SIGNATURE <u>Walter K. Angermeier</u>				M.D. <u>6300 43rd St, NW, Wash. D.C.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Ga Ave NW</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CERTIFICATE OF DEATH

13878

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13828 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

13807

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Silas</u> Middle <u>Edward</u> Last <u>Booth</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-22-83</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Agriculture Dept</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph Booth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mrs. Sarah M. Booth, 232 Dale Drive, Silver Spring, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease, coronary</u> DUE TO (c) <u>thrombosis and myocardial infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 days.</u> <u>13 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Calcific aortic stenosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>Dec 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 24</u> , 19 <u>59</u> , and that death occurred at <u>9:20 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring Md</u> DATE SIGNED <u>Dec 25 59</u> ACTUAL SIGNATURE <u>Aaron H. Traum</u> PHYSICIAN'S NAME (Type) <u>Aaron H. Traum</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 29, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF ANALYSIS

1922

Sample No. 100-1000  
Weight 100.00 gms.  
Date of Analysis 10-10-22  
Analyst J. H. ...  
Location ...  
Remarks ...

U.S. Department of Agriculture  
Washington, D.C.

Mr. J. H. ...  
100-1000  
10-10-22

100-1000  
10-10-22

100-1000  
10-10-22



13871  
CERTIFICATE OF DEATH

Reg. Dist. No.

13808

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>7205-46th. Street</b>		d. STREET ADDRESS <b>7205-46th. Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Simonds</b> Last <b>Boteler, Jr.</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-97</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Harry S. Boteler, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Hess</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578-01-2235</b>	
17. INFORMANT <b>Zella N. Boteler- Item #2 - Wife</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Failure</b> DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Coronary Artery Sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b> <b>8 mos</b> <b>7 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 2, 1958</b> to <b>Dec 27, 1959</b> that I last saw the deceased alive on <b>Dec 24, 1959</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5516 Nebraska Ave DC</b> DATE SIGNED <b>12/27/59</b>			
ACTUAL SIGNATURE <b>Robert B. Havell</b>		M.D. <b>5516 Nebraska Ave DC</b>	
PHYSICIAN'S NAME (Type) <b>Robert B. Havell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3-6-2022

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13872

CERTIFICATE OF DEATH

13809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William G. BOWEN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 29, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Lab.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William George Bowen</u>		14. MOTHER'S MAIDEN NAME <u>Boston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes? + Nephen, Edward Lee Bishop Same.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.1</u> DUE TO <u>Coronary Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Insufficiency</u> (c) <u>Aortic Insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>weeks</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15, 1959</u> , to <u>12-15, 1959</u> that I last saw the deceased alive on <u>12-15, 1959</u> and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1919 Linnemont Rd 12-15-59</u> DATE SIGNED <u>John V. Rogers M.D.</u>			
ACTUAL SIGNATURE <u>John V. Rogers</u> M.D.		PHYSICIAN'S NAME (Type) <u>John V. Rogers</u>	
22a. BURIAL, CREMATION, REBURYAL (Specify) <u>12/17/59</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Ebenezer Church,</u>	
22c. LOCATION (City, town, or county) (State) <u>Ashton, Md.</u>		22d. NAME OF CEMETERY OR CREMATORY	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Christina S. Kneiss</u>		24c. REGISTRAR'S SIGNATURE	

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13845

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# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13872

## CERTIFICATE OF DEATH

Reg. Dist. No. 13810

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>49 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>RFD #2 Box #5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES ALVIN BOYER</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 3 19 59</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/13/89</b>		
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer-Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WESTLY BOYER</b>				14. MOTHER'S MAIDEN NAME <b>Sarah C. Day</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Bronchopneumonia</b> <b>491X</b> DUE TO <b>2. Gastro-Intestinal Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe, due to Congenital Telangiectasia</b> DUE TO <b>3. Urinary Retention, due to prostatic hypertrophy</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 weeks</b> <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Oct. 15, 1959</b> , to <b>Dec. 3, 1959</b> , that I last saw the deceased alive on <b>Dec. 3, 1959</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>GAITHERSBURG, MARYLAND</b> DATE SIGNED <b>12-4-59</b>								
ACTUAL SIGNATURE <b>John Schumacher</b> M.D.								
PHYSICIAN'S NAME (Type) <b>J. SCHUMACHER, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown</b>		22d. LOCATION (City, town, or county) (State) <b>Darnestown, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave., Rockville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>		



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13811

13829

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanatorium &amp; Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. NAME OF DECEASED (Type or print) <i>Harold Lee Briggs, SR.</i>				4. DATE OF DEATH Month <i>12</i> - Day <i>17</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-12-07</i>	
9. AGE (In years lost birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done in most of working life, even if retired) <i>Review attorney fed. Trade Commission</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Texas</i>			
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Other B. Briggs</i>				14. MOTHER'S MAIDEN NAME <i>Florence Mc Millan</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Mrs. Ann A. Briggs</i> Address <i>wife 1812 Powder Mill Road, Silver Spring, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i> <i>11 days</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>July 15, 1956</i> to <i>Dec 17, 1959</i> , that I last saw the deceased alive on <i>Dec 16, 1959</i> , and that death occurred at <i>7:20 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James M. Whitlock M.D.</i>				ADDRESS (Street, city or town, state) <i>2701 Carroll Ave</i> DATE SIGNED <i>12-17-59</i>			
PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>				<i>Takoma Park 12 Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				22b. DATE THEREOF <i>12/20/59</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Geo. Wash. Mem. Cemetery</i>				22d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> ADDRESS <i>SILVER SPRING, MD.</i>				24a. REC'D BY REGISTRAR <i>DATE DEC 21 '59</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

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CERTIFICATE OF DEATH

13822



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death", and "Date" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13812

## CERTIFICATE OF DEATH

Reg. Dist. No.

13874

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3923 Denfeld Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>June</u> Middle <u>Brooke</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 59</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/86</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Clerk (retired) U.S. Treasury</u>				11. BIRTHPLACE (State or foreign country) <u>Nebraska, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac M. Gibbs</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Eva M. Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-50-6539</u>		INFORMANT <u>Son (John T. Brooke) Item #2</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral artery Thrombosis</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>18 DAYS</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aneurysm circle of Willis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 30, 19 57</u> , to <u>Dec 17, 19 59</u> , that I last saw the deceased alive on <u>Dec 17, 19 59</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia ave Silver Spring, Md</u> DATE SIGNED <u>Michael R. Dobridge</u> ACTUAL SIGNATURE <u>Michael R. Dobridge</u> M.D. <u>10620 Georgia ave Silver Spring, Md</u> PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Liska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

CERTIFICATE OF DEATH

1. Name of deceased: *William M. Smith*

2. Sex: *Male*

3. Age: *65*

4. Date of death: *Jan 15 1925*

5. Place of death: *Home*

6. Cause of death: *Heart Disease*

7. Signature of physician: *Dr. J. H. Jones*

8. Signature of registrar: *John D. Smith*

9. Date of registration: *Jan 16 1925*

10. Place of registration: *Boston*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13813

13875

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Alexandria</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> <u>83x-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Basil</u> Middle <u>Henry</u> Last <u>Buchanan</u>				4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 28, 1916</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Cab Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alex Buchanan</u>				14. MOTHER'S MAIDEN NAME <u>Ewrie Angle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>233-07-6624</u>			
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Calcific aortic dilatation</u> DUE TO <u>Coronary arteriosclerosis and generalized arteriosclerosis</u> (c) <u>arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic cholecystitis and cholelithiasis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>5-10 years</u> <u>5-10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 29</u> , 19 <u>59</u> , to <u>December 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 6</u> , 19 <u>59</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/6/59</u> NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>							
ACTUAL SIGNATURE <u>John T. Potts, Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>John T. Potts, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>				22b. DATE THEREOF <u>12/17/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>ALEXANDRIA VA</u>				22d. LOCATION (City, town, or county) (State) <u>IAEGER, WEST, VA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.B. Mountcastle</u> ADDRESS <u>CUNNINGHAM FUNERAL HOME</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13814

13876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>	
c. LENGTH OF STAY IN 1b <u>3-MONS</u>		16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall - Sant.</u>		d. STREET ADDRESS <u>#5 - Horse shoe Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>CADELL</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>16</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Phil. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John McKay</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. Mc Elhatton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Agnes B. Luskey</u> Address <u>#5 - Horse shoe Rd Clinton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 12</u> , 19 <u>59</u> , to <u>DEC. 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC. 30</u> , 19 <u>59</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5306 Norway Dr</u> DATE SIGNED <u>12-30-59</u>			
ACTUAL SIGNATURE <u>Heurigen Towden</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Cherry Chaplin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u> ADDRESS <u>1661 - Good Hope Rd SE WASH. 20 DC</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kenna</u>	

1881

CLIP FROM THE RECORD

1881

5

1

13830  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

Reg. Dist. No. 13815

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Joseph</b> Middle <b>Campbell</b> Last				4. DATE OF DEATH <b>Dec.</b> Month <b>15</b> Day <b>1959</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-18-82</b>	
9. AGE (In years lost birthday) <b>77</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plate Printer</b>		11. BIRTHPLACE (State or foreign country) <b>Distriet of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Cloney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Old Records in Hospital</b>		INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 11, 1959</b> to <b>Dec. 15, 1959</b> ; that I last saw the deceased alive on <b>Dec. 14, 1959</b> , and that death occurred at <b>7:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>A. F. Thibadeau</b>				ADDRESS (Street, city or town, state) <b>10111 Colesville Rd.</b>			
PHYSICIAN'S NAME (Type) <b>A. F. Thibadeau</b>				DATE SIGNED <b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Harris Co. - 2991-14th St. N.W. D.C.</b>				ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 17 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>John S. Harris</b>			

1337

1971

CHRONICALLY ILL DEPT. OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G254 1-4-60 et

13831

## CERTIFICATE OF DEATH

Reg. Dist. No. 13816

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7516 CARROLL AVENUE</b>		d. STREET ADDRESS <b>7516 CARROLL AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CANAVAN</b> Last		4. DATE OF DEATH Month <b>DEC.</b> Day <b>26</b> Year <b>1959.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 17, 1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN CHAMBERS</b>		14. MOTHER'S MAIDEN NAME <b>CLATHERINE NOLAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR JAMES CANAVAN, 7516 CARROLL AVE., MD.</b>		Address <b>TAKOMA PARK, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>434.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr</b> , 1946, to <b>26 Dec</b> , 1959, that I last saw the deceased alive on <b>26 Dec</b> , 1959, and that death occurred at <b>10:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. B. QUEEN</b>		ADDRESS (Street, city or town, state) <b>7112 WILLOW AVE</b> DATE SIGNED <b>26 Dec</b>	
PHYSICIAN'S NAME (Type) <b>H. B. QUEEN</b>		M.D. <b>TAKOMA PARK MD</b> <b>1959.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BLADENSBURG, PR GEO. Co., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Kraus</b>		ADDRESS <b>254 CARROLL ST. N.W., D.C.</b>	
24a. REC'D BY REGISTRAR <b>DEC 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



CERTIFICATE OF DEATH

1931

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF DEATH                  [Faint text]</p>	
<p>5. PLACE OF DEATH                  [Faint text]</p>		<p>6. CAUSE OF DEATH                  [Faint text]</p>	
<p>7. PLACE OF BIRTH                  [Faint text]</p>		<p>8. OCCUPATION                  [Faint text]</p>	
<p>9. MARITAL STATUS                  [Faint text]</p>		<p>10. COLOR                  [Faint text]</p>	
<p>11. EDUCATION                  [Faint text]</p>		<p>12. RELIGION                  [Faint text]</p>	
<p>13. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>14. SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>15. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>16. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>17. SIGNATURE OF NEXT OF KIN                  [Faint text]</p>		<p>18. SIGNATURE OF BURIAL SOCIETY                  [Faint text]</p>	
<p>19. SIGNATURE OF CHURCH                  [Faint text]</p>		<p>20. SIGNATURE OF FUNERAL HOME                  [Faint text]</p>	
<p>21. SIGNATURE OF CEMETERY                  [Faint text]</p>		<p>22. SIGNATURE OF INTERVIEWER                  [Faint text]</p>	
<p>23. SIGNATURE OF ASSISTANT                  [Faint text]</p>		<p>24. SIGNATURE OF CLERK                  [Faint text]</p>	
<p>25. SIGNATURE OF OFFICE                  [Faint text]</p>		<p>26. SIGNATURE OF CHIEF                  [Faint text]</p>	
<p>27. SIGNATURE OF DEPARTMENT                  [Faint text]</p>		<p>28. SIGNATURE OF STATE                  [Faint text]</p>	
<p>29. SIGNATURE OF COUNTY                  [Faint text]</p>		<p>30. SIGNATURE OF CITY                  [Faint text]</p>	
<p>31. SIGNATURE OF TOWNSHIP                  [Faint text]</p>		<p>32. SIGNATURE OF DISTRICT                  [Faint text]</p>	
<p>33. SIGNATURE OF PRESTIGE                  [Faint text]</p>		<p>34. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>35. SIGNATURE OF HONOR                  [Faint text]</p>		<p>36. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>37. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>38. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>39. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>40. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>41. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>42. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>43. SIGNATURE OF HONOR                  [Faint text]</p>		<p>44. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>45. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>46. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>47. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>48. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>49. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>50. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>51. SIGNATURE OF HONOR                  [Faint text]</p>		<p>52. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>53. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>54. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>55. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>56. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>57. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>58. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>59. SIGNATURE OF HONOR                  [Faint text]</p>		<p>60. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>61. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>62. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>63. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>64. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>65. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>66. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>67. SIGNATURE OF HONOR                  [Faint text]</p>		<p>68. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>69. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>70. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>71. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>72. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>73. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>74. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>75. SIGNATURE OF HONOR                  [Faint text]</p>		<p>76. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>77. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>78. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>79. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>80. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>81. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>82. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>83. SIGNATURE OF HONOR                  [Faint text]</p>		<p>84. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>85. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>86. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>87. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>88. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>89. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>90. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>91. SIGNATURE OF HONOR                  [Faint text]</p>		<p>92. SIGNATURE OF GLORY                  [Faint text]</p>	
<p>93. SIGNATURE OF PRAISE                  [Faint text]</p>		<p>94. SIGNATURE OF REVERENCE                  [Faint text]</p>	
<p>95. SIGNATURE OF VENERATION                  [Faint text]</p>		<p>96. SIGNATURE OF ADMIRATION                  [Faint text]</p>	
<p>97. SIGNATURE OF ESTEEM                  [Faint text]</p>		<p>98. SIGNATURE OF RESPECT                  [Faint text]</p>	
<p>99. SIGNATURE OF HONOR                  [Faint text]</p>		<p>100. SIGNATURE OF GLORY                  [Faint text]</p>	

13877

## CERTIFICATE OF DEATH

Reg. Dist. No. 13817

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase 10 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4710 Hunt Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARK</b> Middle <b>E.</b> Last <b>CARRIER</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>27,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 3, 1903</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>24</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stohlman Chev.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Carrier</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Kunselman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-05-6311</b>	
INFORMANT Address <b>Oma Carrier - Item #2 - Wife</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Arterio Sclerotic Heart Disease</b> 17 years + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>17 years +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1942</b> , 19 <b>12/27</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12/27</b> , 19 <b>59</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1150 Conn. Ave., N.W.</b> DATE SIGNED <b>Over</b> ACTUAL SIGNATURE <b>William P. Argy</b> M.D. PHYSICIAN'S NAME (Type) <b>WILLIAM P. ARGY</b> <b>Washington, D. C.</b> <b>12-28-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-30-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF DEATH

1883

in the evening, about 10 o'clock, I saw a man  
about four feet high, with a dark complexion,  
and a very large head, who was walking  
towards the house, and I saw him again  
at least three times. The first time I saw him  
was on the 1st of May, and the second time  
was on the 2nd of May, and the third time  
was on the 3rd of May. I saw him on the 1st of May  
at about 7 P.M. and on the 2nd of May at about 7 P.M.  
and on the 3rd of May at about 7 P.M.

Wm. R. R. S.

12/28/51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13818
13878										Reg. Dist. No.
Baltimore 1 lb. boy										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>26</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>1310 North Van Buren</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BABY GIRL CARROLL</u>					4. DATE OF DEATH <u>DECEMBER 27</u> 19 <u>59</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/59</u>		9. AGE (In years last birthday) yrs. <u>1</u> Min. <u>50</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>PAUL EDWARD CARROLL</u>					14. MOTHER'S MAIDEN NAME <u>IDA MAE GENIES</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>MOTHER</u>			Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 Anoxemia</u> DUE TO (b) <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Immature premature</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>59</u> , to <u>12/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>59</u> , and that death occurred at <u>11:40</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 West Millers Rd Rockville, Md.</u> DATE SIGNED <u>12/29/59</u> ACTUAL SIGNATURE <u>W. F. Colliton, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>William F Colliton Jr MD</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>12-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>800 Old Cemetery Rd Bethesda Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital-800 Old Cemetery Rd Bethesda Md</u>					24a. REC'D BY REGISTRAR <u>12-29-59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>			

13213

CENTRAL DA DAIRY

13213

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13819

13879

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthursburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFO</u>		d. STREET ADDRESS <u>R-1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Paul</u> Last <u>Caulfield</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM S. Caulfield</u>		14. MOTHER'S MAIDEN NAME <u>Eliz. Hunter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Adm C. Madine (daughter)</u>	
17. INFORMANT <u>Stu 2</u>		Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis 2 yrs (arrested)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broseant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broseant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>12-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmett C. Farnum, Garthursburg Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

13820

13880

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write <b>SILVER SPRING</b> ) RURAL and give nearest town		c. CITY OR TOWN (If outside corporate limits, write <b>WASHINGTON</b> ) <b>47x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1800 GRACE CHURCH RD.</b>		d. STREET ADDRESS <b>3610 ORDWAY ST., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>W.</b> Last <b>CHASE</b>		4. DATE OF DEATH Month <b>Dec. 5,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/30/1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	11. IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. ARCHITECT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. NAVY</b>	11. BIRTHPLACE (State or foreign country) <b>COLORADO</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>REV. DEMPSTER W. CHASE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT <b>STANHOPE CHASE, 4844 CHAIN BRIDGE RD.</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>20 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>enlarged prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1957</b> , to <b>Dec 5, 1959</b> , that I last saw the deceased alive on <b>12/5, 1959</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E.H. Markwood</b>		DATE SIGNED <b>3208 - 17th St. N.W. Wash. D.C. 12/5/59</b>	
PHYSICIAN'S NAME (Type) <b>E.H. Markwood, M.D.</b>		3208 17th St., N.W., WASH., D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/8/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLLYWOOD CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>RICHMOND, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Henderson</b>		ADDRESS <b>1756 PA. AVE., N.W.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02454

100

13881

## CERTIFICATE OF DEATH

Reg. Dist. No.

13821

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>8 days 6 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Vasilios</b> Middle <b>I.</b> Last <b>Chebithes</b>				4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/15/1894</b>	
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>	
13. FATHER'S NAME <b>Isadore Chebithes</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>1917 - 18 290-18-2363</b>			
17. INFORMANT <b>Julia Sapounakis</b>				Address <b>4813 Bayard Blvd. Bethesda Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>IRREVERSIBLE SHOCK &amp; TOXEMIA</b> 578x DUE TO <b>Massive ABDOMINAL ABSCESS;</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO (c) <b>Perforated appendix, Intestinal obstruction</b> INTERVAL BETWEEN ONSET AND DEATH <b>approx. 18 days.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>atelectasis, Lungs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>12 - 1 - 1959</b> , to <b>12 - 10 - 1959</b> , that I last saw the deceased alive on <b>12 - 9 - 59</b> , 19, and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Linwood H. Johnson</b> M.D.				ADDRESS (Street, city or town, state) <b>4630 Montgomerystowne, 12-12-59 Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Linwood H. Johnson</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Fennell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1981

CERTIFICATE OF DEATH

1981



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to blurriness.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13882  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG254 1-22-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13822

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SOPHIE</b> Middle <b>C</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 14, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>00</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas Clagett</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Eicher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Elizabeth Clark -5424 Neb Ave Wash. D.C.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHIAL PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>DEC. 7, 1959</b> to <b>DEC. 14, 1959</b> , that I last saw the deceased alive on <b>DEC. 14, 1959</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Henry Lowden M.D.</b>		ADDRESS (Street, city or town, state) <b>5206 Norway Dr. 12/14/59</b>	
PHYSICIAN'S NAME (Type) <b>Henry Lowden</b>		DATE SIGNED <b>Cherry Chow, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematorium</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Jones</b>		ADDRESS <b>Wash. D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



CERTIFICATE OF DEATH

13883

STATE OF NEW YORK  
COUNTY OF [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13823

13857

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>607 Blanford Ave - apt 3</u>				d. STREET ADDRESS <u>607 Blanford Ave - apt 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Willis Court Clem</u>				<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>14</u> Year <u>1959</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9-5-1913</u>	
<b>9. AGE</b> (In years last birthday) <u>46 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>46</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		<b>11. IF UNDER 24 HRS.</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>air conditioning</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N. I. H.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Va</u>	
<b>13. FATHER'S NAME</b> <u>Adeline E. Clem</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annice Lloyd</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>W. W. H.</u>		<b>17. INFORMANT</b> <u>Virginia Clem (wif.)</u>		<b>18. ADDRESS</b> <u>Stem 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusions</u> <u>420.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. m.</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosch</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosch</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>12-14-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Bur-transit</u>		<b>22b. DATE THEREOF</b> <u>12/16/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sunset</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Christiansburg, Virginia</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DEC 18 '59</u>			
<b>ADDRESS</b> <u>1331 E. Montg. Ave., Rockville, Md.</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Frank</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1882

NEW YORK

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER		10. DATE OF EXAMINATION	
11. PLACE OF DEATH		12. TIME OF DEATH		13. TEMPERATURE		14. PULSE		15. RESPIRATION		16. CONSCIOUSNESS		17. COLOR OF SKIN		18. COLOR OF MUCOSAE		19. COLOR OF URINE		20. COLOR OF STOOL	
21. HISTORY OF PRESENT ILLNESS		22. PREVIOUS ILLNESSES		23. SURGICAL HISTORY		24. MEDICAL HISTORY		25. SOCIAL HISTORY		26. FAMILY HISTORY		27. PERSONAL HISTORY		28. PHYSICAL EXAMINATION		29. LABORATORY EXAMINATIONS		30. OTHER EXAMINATIONS	
31. POST-MORTEM FINDINGS		32. GROSS FINDINGS		33. MICROSCOPIC FINDINGS		34. BACTERIOLOGICAL FINDINGS		35. RADIOLOGICAL FINDINGS		36. OTHER FINDINGS		37. CONCLUSIONS		38. RECOMMENDATIONS		39. SIGNATURE OF EXAMINER		40. DATE OF EXAMINATION	

## CERTIFICATE OF DEATH

Reg. Dist. No.

13824

13883

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>42 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WHEATON</u> d. STREET ADDRESS <u>12004 CENTER HILL STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>LOUISE</u> Last <u>Collins</u>			4. DATE OF DEATH Month <u>12</u> Day <u>5</u> Year <u>1959</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-1922</u>	9. AGE (In years lost birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOMEMAKER</u>		11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>ALBERT E. PRESTLE</u>		
14. MOTHER'S MAIDEN NAME <u>MARY ADALADE NASH</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>INFORMANT</u>			Address <u>Mr. Francis Collins SAME AS ABOVE</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF OVARY</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>APPROX. 8 WKS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>ABOUT OCT. 15 1959</u> to <u>DEC. 5, 1959</u> , that I last saw the deceased alive on <u>DEC. 5, 1959</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John H. Tuohy</u>		ADDRESS (Street, city or town, state) <u>7720 Wisconsin Ave. Bethesda, Md.</u>		DATE SIGNED <u>12/5/59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY</u>		ADDRESS <u>7720 WISCONSIN AVE. BETHESDA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821-14th St. NW, Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF

1980

10/1/80

1. Name of the person: [illegible]  
2. Date of birth: [illegible]  
3. Sex: [illegible]  
4. Race: [illegible]  
5. Marital status: [illegible]  
6. Address: [illegible]  
7. City: [illegible]  
8. State: [illegible]  
9. Zip: [illegible]  
10. Signature: [illegible]  
11. Date: [illegible]  
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97. [illegible]  
98. [illegible]  
99. [illegible]  
100. [illegible]

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13825

HOSP. COPY

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>12 hrs. 45 mins.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>4810 Leland Street</b>	
3. NAME OF DECEASED (Type or print) <b>John A. Corbin</b>		4. DATE OF DEATH <b>Dec. 11 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/96</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Francis Corbin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gallagher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm of ant. cerebral artery</b> <b>9040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fell at home 10-31-59 and struck forehead on concrete floor</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <b>Month, Day, Year</b> Hour <b>3</b> o. m. <b>10-11</b> 19 <b>59</b>	20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Chevy Chase Md</b> (County) <b>mt</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		22d. LOCATION (City, town, or county) <b>Silver Spring, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

VS. A15ME(5)  
SM 9/55





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13826

13885

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11731 College View Dr</u>				d. STREET ADDRESS <u>11731 College View Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Corder</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1917</u>	
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. Health Inspector</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wilfred G. Corder</u>				14. MOTHER'S MAIDEN NAME <u>Eliz. Fitzgerald</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW II</u> <u>579-10-6987</u>		17. INFORMANT <u>Margaret Corder (wife)</u> Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		22b. DATE THEREOF <u>12-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Matthew Haulon</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13886

CERTIFICATE OF DEATH

13827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>34 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>10601 Nash Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JULIAN SMITH COTTRELL</u>				4. DATE OF DEATH <u>Dec. 1, 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1899</u>	9. AGE (In years lost birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Julian S. Cottrell</u>				14. MOTHER'S MAIDEN NAME <u>Eva Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>MISS Evelyn C. Cottrell, (Same as #2)</u>			
17. INFORMANT <u>Miss Evelyn C. Cottrell, (Same as #2)</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bronchus</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>16 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/20/59</u> 19 to <u>12/1/59</u> 19, that I last saw the deceased alive on <u>12/1/59</u> 19, and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia Ave</u> DATE SIGNED <u>12/1/59</u>							
ACTUAL SIGNATURE <u>Julian J. Curry M.D.</u>				PHYSICIAN'S NAME (Type) <u>Julian J. Curry M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec. 3, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fair Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

13884

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
PHYSICIAN'S SIGNATURE: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G253 12-23-59 et

13887

## CERTIFICATE OF DEATH

Reg. Dist. No. 13828

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN lb <u>3 YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8628 PINEY BRANCH ROAD</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MARYLAND</u> d. STREET ADDRESS <u>18628 PINEY BRANCH ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>MARY</u> Last <u>CRONIN</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASOID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882</u> <u>SEPT. 27, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MICHAEL REARDON</u>		14. MOTHER'S MAIDEN NAME <u>MARY Foley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>MISS MARGARET CRONIN</u> Address <u>8628 PINEY BRANCH RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>462.1 CARDIOVASCULAR COLLAPSE</u> DUE TO (b) <u>HEMORRHAGE-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ESOPHAGEAL VARICES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>6 HOURS</u> <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC CIRRHOSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>55</u> , to <u>DEC. 11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DEC. 11</u> , 19 <u>59</u> , and that death occurred at <u>6:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u>		ADDRESS (Street, city or town, state) <u>9420 OLD GEORGETOWN RD.</u> DATE SIGNED <u>DEC. 11, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		<u>BETHESDA 14, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF <u>12/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>St. Mary's Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Huntington</u>		ADDRESS <u>5732</u>	
24a. REC'D BY REGISTRAR <u>DATE DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	



CERTIFICATE OF DEATH 13887

8

*[Faint, mostly illegible text on a form with horizontal lines. The text appears to be a medical or official record, possibly a death certificate, with fields for name, date, and other details. The handwriting is very light and difficult to decipher.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13829

Reg. Dist. No.

13888

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Montgomery</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Montgomery</span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Bethesda</span>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Bethesda</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">5835 Conway Road</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">5835 Conway Road</span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">Clarence</span> Middle <span style="font-size: 1.2em;">A</span> Last <span style="font-size: 1.2em;">Crowe</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">Dec.</span> Day <span style="font-size: 1.2em;">8</span> Year <span style="font-size: 1.2em;">19 59</span>				
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">May 16, 1908</span>		
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">51 yrs.</span>		<b>IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;">6</span> Days <span style="font-size: 1.2em;">12</span>		<b>IF UNDER 24 HRS.</b> Hours <span style="font-size: 1.2em;"></span> Min. <span style="font-size: 1.2em;"></span>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Military Planning</span>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Officer USA</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Pennsylvania</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">George Crowe</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Louella Reep</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">Yes</span> <span style="font-size: 1.2em;">WW II</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">555-40-8479</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Irene Crowe-wife-same as 2d</span>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Coronary occlusion</span>  <b>420.1</b> <span style="float: right;">DUE TO</span>          Conditions, if any, which gave rise to immediate cause (b) <span style="float: right;">DUE TO</span>          (c), stating the underlying cause last. <span style="float: right;">DUE TO</span> </div>							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">Found dead in bed</span>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <span style="font-size: 1.2em;">19</span> Hour <span style="font-size: 1.2em;"></span> a. m. <span style="font-size: 1.2em;"></span> p. m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>								
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">Frank J. Broschart</span> <span style="float: right;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">Frank J. Broschart</span>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">12-11-59</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Arlington National</span>		<b>22d. LOCATION (City, town, or county)</b> (State) <span style="font-size: 1.2em;">Arlington, Virginia</span>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">ROBERT A. PUMPHREY</span>				<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">Bethesda, Md.</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">DEC 10 '59</span>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13889  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13831

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSP.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MORCAS</b>		Middle <b>REBECCA</b>		Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2 1885</b>		9. AGE (In years lost birthday) <b>74 yrs.</b>	10. IF UNDER 1 YEAR Months <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>-- Hiram Nesselrodt</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA K. --</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Asphyxia, pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiac muscle disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1955</b> , to <b>Dec 1958</b> , that I last saw the deceased alive on <b>Dec 25</b> , 1958, and that death occurred at <b>5:55 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>A. D. Bonifant</b> M.D. <b>Sandy Spring Md</b> <b>12/30/58</b> PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b> <b>SANDY SPRING, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 28 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Redland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 31 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13890

## CERTIFICATE OF DEATH

13832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Howard</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>				c. LENGTH OF STAY IN 1b <i>3 mo 5 da</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>				d. STREET ADDRESS <i>West Friendship 13x-2</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>James Edward Day</i>				4. DATE OF DEATH Month Day Year <i>Dec 5 1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cauc</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 29 1915</i>	
9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm Owner</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME <i>James Day</i>				14. MOTHER'S MAIDEN NAME <i>Martha Parsley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mary Mullini X West Friendship Howard Co, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i> <i>690.7</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Tuberculosis</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hemiplegia</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>12/4</i> , 19 <i>59</i> , to <i>12/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/5</i> , 19 <i>59</i> , and that death occurred at <i>6:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. H. Higinbotham</i>				ADDRESS (Street, city or town, state) <i>Alpha, Md</i>			
PHYSICIAN'S NAME (Type) <i>C. H. Higinbotham MD</i>				DATE SIGNED <i>12/6/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-8-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. View</i>		22d. LOCATION (City, town, or county) (State) <i>Alpha, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F.C. Higinbotham, Ellicott City, Md</i>				ADDRESS			
24a. REC'D BY REGISTRAR <i>DEC 8 '59</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1915

Rev. 10-1-14

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		Jan 1, 1870		Maryland		Baltimore		Heart Disease		Jan 15, 1915		City		Dr. J. Smith		J. Doe		J. Doe	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. County		19. District		20. Precinct		21. Ward		22. Block		23. Lot		24. Sublot	
John Doe		Son		123 Main St		Baltimore		Maryland		Baltimore		City		Precinct		Ward		Block		Lot		Sublot	
25. Name of registrar		26. Signature		27. Date		28. Time		29. Place		30. County		31. District		32. Precinct		33. Ward		34. Block		35. Lot		36. Sublot	
J. Doe		J. Doe		Jan 15, 1915		10:00 AM		City		Baltimore		City		Precinct		Ward		Block		Lot		Sublot	
37. Name of informant		38. Relationship		39. Address		40. City		41. State		42. County		43. District		44. Precinct		45. Ward		46. Block		47. Lot		48. Sublot	
John Doe		Son		123 Main St		Baltimore		Maryland		Baltimore		City		Precinct		Ward		Block		Lot		Sublot	
49. Name of registrar		50. Signature		51. Date		52. Time		53. Place		54. County		55. District		56. Precinct		57. Ward		58. Block		59. Lot		60. Sublot	
J. Doe		J. Doe		Jan 15, 1915		10:00 AM		City		Baltimore		City		Precinct		Ward		Block		Lot		Sublot	

FILED  
JAN 16 1915  
BALTIMORE

OF IN U S A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13891

## CERTIFICATE OF DEATH

Reg. Dist. No.

13833

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4840 Bayard Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LAURA MAE DECKER</b>		4. DATE OF DEATH <b>December 22, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 28, 1889</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR <b>10 24</b> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James B. Burch</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Colton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not in, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Harold Ham-Item #2- Daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19 59</b> Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH <b>less than hour</b> 20h. years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Dec. 28, 19 50</b> , to <b>present</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 22, 19 59</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4400 - 49th St. N.W. Washington 16, D.C.</b> DATE SIGNED <b>12-22-59</b> ACTUAL SIGNATURE <b>C. P. Ryland</b> M.D. PHYSICIAN'S NAME (Type) <b>C. P. RYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-24-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13834

13892

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>12,502 FELDON STREET</b>				d. STREET ADDRESS <b>12,502 FELDON STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALZIRE (nmi) DEMERS</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 1 19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 10, 1887</b>	
9. AGE (In years last birthday) <b>72 yrs.</b>		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STAPLER (retired) PAPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BOX MANUFACTURING</b>		11. BIRTHPLACE (State or foreign country) <b>CANADA</b>	
13. FATHER'S NAME <b>FABIEN LEGER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>062-20-9085A</b>		17. INFORMANT <b>F.</b> Address <b>Spring, Md.</b>		18. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (b) <b>(FOND DEAD IN BED)</b> (c) <b>(FOND DEAD IN BED)</b> DUE TO <b>(FOND DEAD IN BED)</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 12/5/59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>PANISH CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OGDENSBURG, NEW YORK</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

18-BIRMINGHAM-HEALTH DEPARTMENT STATE OF ALABAMA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White	
5. DATE OF DEATH April 4, 1968		6. TIME OF DEATH 2:01 PM		7. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		8. CITY Memphis	
9. COUNTY Shelby		10. STATE Tennessee		11. ZIP CODE 38103		12. MARRIED <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
13. OCCUPATION Attorney		14. EDUCATION High School Graduate		15. RELIGION Methodist		16. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
17. CAUSE OF DEATH Suicide by gunshot wound of the chest		18. MANNER OF DEATH Homicide		19. MECHANISM OF DEATH Gunshot wound of the chest		20. WEAPON Revolver	
21. TOXICOLOGY None		22. ALCOHOL None		23. DRUGS None		24. OTHER None	
25. SIGNATURE OF EXAMINER [Signature]		26. TITLE Medical Examiner		27. DATE April 4, 1968		28. TIME 2:01 PM	
29. SIGNATURE OF DECEASED [Signature]		30. TITLE Deceased		31. DATE April 4, 1968		32. TIME 2:01 PM	
33. SIGNATURE OF WITNESS [Signature]		34. TITLE Witness		35. DATE April 4, 1968		36. TIME 2:01 PM	
37. SIGNATURE OF CORONER [Signature]		38. TITLE Coroner		39. DATE April 4, 1968		40. TIME 2:01 PM	
41. SIGNATURE OF JURY [Signature]		42. TITLE Jury		43. DATE April 4, 1968		44. TIME 2:01 PM	
45. SIGNATURE OF JUDGE [Signature]		46. TITLE Judge		47. DATE April 4, 1968		48. TIME 2:01 PM	
49. SIGNATURE OF PROSECUTOR [Signature]		50. TITLE Prosecutor		51. DATE April 4, 1968		52. TIME 2:01 PM	
53. SIGNATURE OF DEFENSE [Signature]		54. TITLE Defense		55. DATE April 4, 1968		56. TIME 2:01 PM	
57. SIGNATURE OF JURY [Signature]		58. TITLE Jury		59. DATE April 4, 1968		60. TIME 2:01 PM	
61. SIGNATURE OF JUDGE [Signature]		62. TITLE Judge		63. DATE April 4, 1968		64. TIME 2:01 PM	
65. SIGNATURE OF PROSECUTOR [Signature]		66. TITLE Prosecutor		67. DATE April 4, 1968		68. TIME 2:01 PM	
69. SIGNATURE OF DEFENSE [Signature]		70. TITLE Defense		71. DATE April 4, 1968		72. TIME 2:01 PM	
73. SIGNATURE OF JURY [Signature]		74. TITLE Jury		75. DATE April 4, 1968		76. TIME 2:01 PM	
77. SIGNATURE OF JUDGE [Signature]		78. TITLE Judge		79. DATE April 4, 1968		80. TIME 2:01 PM	
81. SIGNATURE OF PROSECUTOR [Signature]		82. TITLE Prosecutor		83. DATE April 4, 1968		84. TIME 2:01 PM	
85. SIGNATURE OF DEFENSE [Signature]		86. TITLE Defense		87. DATE April 4, 1968		88. TIME 2:01 PM	
89. SIGNATURE OF JURY [Signature]		90. TITLE Jury		91. DATE April 4, 1968		92. TIME 2:01 PM	
93. SIGNATURE OF JUDGE [Signature]		94. TITLE Judge		95. DATE April 4, 1968		96. TIME 2:01 PM	
97. SIGNATURE OF PROSECUTOR [Signature]		98. TITLE Prosecutor		99. DATE April 4, 1968		100. TIME 2:01 PM	
101. SIGNATURE OF DEFENSE [Signature]		102. TITLE Defense		103. DATE April 4, 1968		104. TIME 2:01 PM	
105. SIGNATURE OF JURY [Signature]		106. TITLE Jury		107. DATE April 4, 1968		108. TIME 2:01 PM	
109. SIGNATURE OF JUDGE [Signature]		110. TITLE Judge		111. DATE April 4, 1968		112. TIME 2:01 PM	
113. SIGNATURE OF PROSECUTOR [Signature]		114. TITLE Prosecutor		115. DATE April 4, 1968		116. TIME 2:01 PM	
117. SIGNATURE OF DEFENSE [Signature]		118. TITLE Defense		119. DATE April 4, 1968		120. TIME 2:01 PM	
121. SIGNATURE OF JURY [Signature]		122. TITLE Jury		123. DATE April 4, 1968		124. TIME 2:01 PM	
125. SIGNATURE OF JUDGE [Signature]		126. TITLE Judge		127. DATE April 4, 1968		128. TIME 2:01 PM	
129. SIGNATURE OF PROSECUTOR [Signature]		130. TITLE Prosecutor		131. DATE April 4, 1968		132. TIME 2:01 PM	
133. SIGNATURE OF DEFENSE [Signature]		134. TITLE Defense		135. DATE April 4, 1968		136. TIME 2:01 PM	
137. SIGNATURE OF JURY [Signature]		138. TITLE Jury		139. DATE April 4, 1968		140. TIME 2:01 PM	
141. SIGNATURE OF JUDGE [Signature]		142. TITLE Judge		143. DATE April 4, 1968		144. TIME 2:01 PM	
145. SIGNATURE OF PROSECUTOR [Signature]		146. TITLE Prosecutor		147. DATE April 4, 1968		148. TIME 2:01 PM	
149. SIGNATURE OF DEFENSE [Signature]		150. TITLE Defense		151. DATE April 4, 1968		152. TIME 2:01 PM	
153. SIGNATURE OF JURY [Signature]		154. TITLE Jury		155. DATE April 4, 1968		156. TIME 2:01 PM	
157. SIGNATURE OF JUDGE [Signature]		158. TITLE Judge		159. DATE April 4, 1968		160. TIME 2:01 PM	
161. SIGNATURE OF PROSECUTOR [Signature]		162. TITLE Prosecutor		163. DATE April 4, 1968		164. TIME 2:01 PM	
165. SIGNATURE OF DEFENSE [Signature]		166. TITLE Defense		167. DATE April 4, 1968		168. TIME 2:01 PM	
169. SIGNATURE OF JURY [Signature]		170. TITLE Jury		171. DATE April 4, 1968		172. TIME 2:01 PM	
173. SIGNATURE OF JUDGE [Signature]		174. TITLE Judge		175. DATE April 4, 1968		176. TIME 2:01 PM	
177. SIGNATURE OF PROSECUTOR [Signature]		178. TITLE Prosecutor		179. DATE April 4, 1968		180. TIME 2:01 PM	
181. SIGNATURE OF DEFENSE [Signature]		182. TITLE Defense		183. DATE April 4, 1968		184. TIME 2:01 PM	
185. SIGNATURE OF JURY [Signature]		186. TITLE Jury		187. DATE April 4, 1968		188. TIME 2:01 PM	
189. SIGNATURE OF JUDGE [Signature]		190. TITLE Judge		191. DATE April 4, 1968		192. TIME 2:01 PM	
193. SIGNATURE OF PROSECUTOR [Signature]		194. TITLE Prosecutor		195. DATE April 4, 1968		196. TIME 2:01 PM	
197. SIGNATURE OF DEFENSE [Signature]		198. TITLE Defense		199. DATE April 4, 1968		200. TIME 2:01 PM	
201. SIGNATURE OF JURY [Signature]		202. TITLE Jury		203. DATE April 4, 1968		204. TIME 2:01 PM	
205. SIGNATURE OF JUDGE [Signature]		206. TITLE Judge		207. DATE April 4, 1968		208. TIME 2:01 PM	
209. SIGNATURE OF PROSECUTOR [Signature]		210. TITLE Prosecutor		211. DATE April 4, 1968		212. TIME 2:01 PM	
213. SIGNATURE OF DEFENSE [Signature]		214. TITLE Defense		215. DATE April 4, 1968		216. TIME 2:01 PM	
217. SIGNATURE OF JURY [Signature]		218. TITLE Jury		219. DATE April 4, 1968		220. TIME 2:01 PM	
221. SIGNATURE OF JUDGE [Signature]		222. TITLE Judge		223. DATE April 4, 1968		224. TIME 2:01 PM	
225. SIGNATURE OF PROSECUTOR [Signature]		226. TITLE Prosecutor		227. DATE April 4, 1968		228. TIME 2:01 PM	
229. SIGNATURE OF DEFENSE [Signature]		230. TITLE Defense		231. DATE April 4, 1968		232. TIME 2:01 PM	
233. SIGNATURE OF JURY [Signature]		234. TITLE Jury		235. DATE April 4, 1968		236. TIME 2:01 PM	
237. SIGNATURE OF JUDGE [Signature]		238. TITLE Judge		239. DATE April 4, 1968		240. TIME 2:01 PM	
241. SIGNATURE OF PROSECUTOR [Signature]		242. TITLE Prosecutor		243. DATE April 4, 1968		244. TIME 2:01 PM	
245. SIGNATURE OF DEFENSE [Signature]		246. TITLE Defense		247. DATE April 4, 1968		248. TIME 2:01 PM	
249. SIGNATURE OF JURY [Signature]		250. TITLE Jury		251. DATE April 4, 1968		252. TIME 2:01 PM	
253. SIGNATURE OF JUDGE [Signature]		254. TITLE Judge		255. DATE April 4, 1968		256. TIME 2:01 PM	
257. SIGNATURE OF PROSECUTOR [Signature]		258. TITLE Prosecutor		259. DATE April 4, 1968		260. TIME 2:01 PM	
261. SIGNATURE OF DEFENSE [Signature]		262. TITLE Defense		263. DATE April 4, 1968		264. TIME 2:01 PM	
265. SIGNATURE OF JURY [Signature]		266. TITLE Jury		267. DATE April 4, 1968		268. TIME 2:01 PM	
269. SIGNATURE OF JUDGE [Signature]		270. TITLE Judge		271. DATE April 4, 1968		272. TIME 2:01 PM	
273. SIGNATURE OF PROSECUTOR [Signature]		274. TITLE Prosecutor		275. DATE April 4, 1968		276. TIME 2:01 PM	
277. SIGNATURE OF DEFENSE [Signature]		278. TITLE Defense		279. DATE April 4, 1968		280. TIME 2:01 PM	
281. SIGNATURE OF JURY [Signature]		282. TITLE Jury		283. DATE April 4, 1968		284. TIME 2:01 PM	
285. SIGNATURE OF JUDGE [Signature]		286. TITLE Judge		287. DATE April 4, 1968		288. TIME 2:01 PM	
289. SIGNATURE OF PROSECUTOR [Signature]		290. TITLE Prosecutor		291. DATE April 4, 1968		292. TIME 2:01 PM	
293. SIGNATURE OF DEFENSE [Signature]		294. TITLE Defense		295. DATE April 4, 1968		296. TIME 2:01 PM	
297. SIGNATURE OF JURY [Signature]		298. TITLE Jury		299. DATE April 4, 1968		300. TIME 2:01 PM	
301. SIGNATURE OF JUDGE [Signature]		302. TITLE Judge		303. DATE April 4, 1968		304. TIME 2:01 PM	
305. SIGNATURE OF PROSECUTOR [Signature]		306. TITLE Prosecutor		307. DATE April 4, 1968		308. TIME 2:01 PM	
309. SIGNATURE OF DEFENSE [Signature]		310. TITLE Defense		311. DATE April 4, 1968		312. TIME 2:01 PM	
313. SIGNATURE OF JURY [Signature]		314. TITLE Jury		315. DATE April 4, 1968		316. TIME 2:01 PM	
317. SIGNATURE OF JUDGE [Signature]		318. TITLE Judge		319. DATE April 4, 1968		320. TIME 2:01 PM	
321. SIGNATURE OF PROSECUTOR [Signature]		322. TITLE Prosecutor		323. DATE April 4, 1968		324. TIME 2:01 PM	
325. SIGNATURE OF DEFENSE [Signature]		326. TITLE Defense		327. DATE April 4, 1968		328. TIME 2:01 PM	
329. SIGNATURE OF JURY [Signature]		330. TITLE Jury		331. DATE April 4, 1968		332. TIME 2:01 PM	
333. SIGNATURE OF JUDGE [Signature]		334. TITLE Judge		335. DATE April 4, 1968		336. TIME 2:01 PM	
337. SIGNATURE OF PROSECUTOR [Signature]		338. TITLE Prosecutor		339. DATE April 4, 1968		340. TIME 2:01 PM	
341. SIGNATURE OF DEFENSE [Signature]		342. TITLE Defense		343. DATE April 4, 1968		344. TIME 2:01 PM	
345. SIGNATURE OF JURY [Signature]		346. TITLE Jury		347. DATE April 4, 1968		348. TIME 2:01 PM	
349. SIGNATURE OF JUDGE [Signature]		350. TITLE Judge		351. DATE April 4, 1968		352. TIME 2:01 PM	
353. SIGNATURE OF PROSECUTOR [Signature]		354. TITLE Prosecutor		355. DATE April 4, 1968		356. TIME 2:01 PM	
357. SIGNATURE OF DEFENSE [Signature]		358. TITLE Defense		359. DATE April 4, 1968		360. TIME 2:01 PM	
361. SIGNATURE OF JURY [Signature]		362. TITLE Jury		363. DATE April 4, 1968		364. TIME 2:01 PM	
365. SIGNATURE OF JUDGE [Signature]		366. TITLE Judge		367. DATE April 4, 1968		368. TIME 2:01 PM	
369. SIGNATURE OF PROSECUTOR [Signature]		370. TITLE Prosecutor		371. DATE April 4, 1968		372. TIME 2:01 PM	
373. SIGNATURE OF DEFENSE [Signature]		374. TITLE Defense		375. DATE April 4, 1968		376. TIME 2:01 PM	
377. SIGNATURE OF JURY [Signature]		378. TITLE Jury		379. DATE April 4, 1968		380. TIME 2:01 PM	
381. SIGNATURE OF JUDGE [Signature]		382. TITLE Judge		383. DATE April 4, 1968		384. TIME 2:01 PM	
385. SIGNATURE OF PROSECUTOR [Signature]		386. TITLE Prosecutor		387. DATE April 4, 1968		388. TIME 2:01 PM	
389. SIGNATURE OF DEFENSE [Signature]		390. TITLE Defense		391. DATE April 4, 1968		392. TIME 2:01 PM	
393. SIGNATURE OF JURY [Signature]		394. TITLE Jury		395. DATE April 4, 1968		396. TIME 2:01 PM	
397. SIGNATURE OF JUDGE [Signature]		398. TITLE Judge		399. DATE April 4, 1968		400. TIME 2:01 PM	
401. SIGNATURE OF PROSECUTOR [Signature]		402. TITLE Prosecutor		403. DATE April 4, 1968		404. TIME 2:01 PM	
405. SIGNATURE OF DEFENSE [Signature]		406. TITLE Defense		407. DATE April 4, 1968		408. TIME 2:01 PM	
409. SIGNATURE OF JURY [Signature]		410. TITLE Jury		411. DATE April 4, 1968		412. TIME 2:01 PM	
413. SIGNATURE OF JUDGE [Signature]		414. TITLE Judge		415. DATE April 4, 1968		416. TIME 2:01 PM	
417. SIGNATURE OF PROSECUTOR [Signature]		418. TITLE Prosecutor		419. DATE April 4, 1968		420. TIME 2:01 PM	
421. SIGNATURE OF DEFENSE [Signature]		422. TITLE Defense		423. DATE April 4, 1968		424. TIME 2:01 PM	
425. SIGNATURE OF JURY [Signature]		426. TITLE Jury		427. DATE April 4, 1968		428. TIME 2:01 PM	
429. SIGNATURE OF JUDGE [Signature]		430. TITLE Judge		431. DATE April 4, 1968		432. TIME 2:01 PM	
433. SIGNATURE OF PROSECUTOR [Signature]		434. TITLE Prosecutor		435. DATE April 4, 1968		436. TIME 2:01 PM	
437. SIGNATURE OF DEFENSE [Signature]		438. TITLE Defense		439. DATE April 4, 1968		440. TIME 2:01 PM	
441. SIGNATURE OF JURY [Signature]		442. TITLE Jury		443. DATE April 4, 1968		444. TIME 2:01 PM	
445. SIGNATURE OF JUDGE [Signature]		446. TITLE Judge		447. DATE April 4, 1968		448. TIME 2:01 PM	
449. SIGNATURE OF PROSECUTOR [Signature]		450. TITLE Prosecutor		451. DATE April 4, 1968		452. TIME 2:01 PM	
453. SIGNATURE OF DEFENSE [Signature]		454. TITLE Defense		455. DATE April 4, 1968		456. TIME 2:01 PM	
457. SIGNATURE OF JURY [Signature]		458. TITLE Jury		459. DATE April 4, 1968		460. TIME 2:01 PM	
461. SIGNATURE OF JUDGE [Signature]		462. TITLE Judge		463. DATE April 4, 1968		464. TIME 2:01 PM	
465. SIGNATURE OF PROSECUTOR [Signature]		466. TITLE Prosecutor		467. DATE April 4, 1968		468. TIME 2:01 PM	
469. SIGNATURE OF DEFENSE [Signature]		470. TITLE Defense		471. DATE April 4, 1968		472. TIME 2:01 PM	
473. SIGNATURE OF JURY [Signature]		474. TITLE Jury		475. DATE April 4, 1968		476. TIME 2:01 PM	
477. SIGNATURE OF JUDGE [Signature]		478. TITLE Judge		479. DATE April 4, 1968		480. TIME 2:01 PM	
481. SIGNATURE OF PROSECUTOR [Signature]		482. TITLE Prosecutor		483. DATE April 4, 1968		484. TIME 2:01 PM	
485. SIGNATURE OF DEFENSE [Signature]		486. TITLE Defense		487. DATE April 4, 1968		488. TIME 2:01 PM	
489. SIGNATURE OF JURY [Signature]		490. TITLE Jury		491. DATE April 4, 1968		492. TIME 2:01 PM	
493. SIGNATURE OF JUDGE [Signature]		494. TITLE Judge		495. DATE April 4, 1968		496. TIME 2:01 PM	
497. SIGNATURE OF PROSECUTOR [Signature]		498. TITLE Prosecutor		499. DATE April 4, 1968		500. TIME 2:01 PM	
501. SIGNATURE OF DEFENSE [Signature]		502. TITLE Defense		503. DATE April 4, 1968		504. TIME 2:01 PM	
505. SIGNATURE OF JURY [Signature]		506. TITLE Jury		507. DATE April 4, 1968		508. TIME 2:01 PM	
509. SIGNATURE OF JUDGE [Signature]		510. TITLE Judge		511. DATE April 4, 1968		512. TIME 2:01 PM	
513. SIGNATURE OF PROSECUTOR [Signature]		514. TITLE Prosecutor		515. DATE April 4, 1968		516. TIME 2:01 PM	
517. SIGNATURE OF DEFENSE [Signature]		518. TITLE Defense		519. DATE April 4, 1968		520. TIME 2:01 PM	
521. SIGNATURE OF JURY [Signature]		522. TITLE Jury		523. DATE April 4, 1968		524. TIME 2:01 PM	
525. SIGNATURE OF JUDGE [Signature]		526. TITLE Judge		527. DATE April 4, 1968		528. TIME 2:01 PM	
529. SIGNATURE OF PROSECUTOR [Signature]		530. TITLE Prosecutor		531. DATE April 4, 1968		532. TIME 2:01 PM	
533. SIGNATURE OF DEFENSE [Signature]		534. TITLE Defense		535. DATE April 4, 1968		536. TIME 2:01 PM	
537. SIGNATURE OF JURY [Signature]		538. TITLE Jury		539. DATE April 4, 1968		540. TIME 2:01 PM	
541. SIGNATURE OF JUDGE [Signature]		542. TITLE Judge		543. DATE April 4, 1968		544. TIME 2:01 PM	
545. SIGNATURE OF PROSECUTOR [Signature]		546. TITLE Prosecutor		547. DATE April 4, 1968		548. TIME 2:01 PM	
549. SIGNATURE OF DEFENSE [Signature]		550. TITLE Defense		551. DATE April 4, 1968		552. TIME 2:01 PM	
553. SIGNATURE OF JURY [Signature]		554. TITLE Jury		555. DATE April 4, 1968		556. TIME 2:01 PM	
557. SIGNATURE OF JUDGE [Signature]		558. TITLE Judge		559. DATE April 4, 1968		560. TIME 2:01 PM	
561. SIGNATURE OF PROSECUTOR [Signature]		562. TITLE Prosecutor		563. DATE April 4, 1968		564. TIME 2:01 PM	
565. SIGNATURE OF DEFENSE [Signature]		566. TITLE Defense		567. DATE April 4, 1968		568. TIME 2:01 PM	
569. SIGNATURE OF JURY [Signature]		570. TITLE Jury		571. DATE April 4, 1968		572. TIME 2:01 PM	
573. SIGNATURE OF JUDGE [Signature]		574. TITLE Judge		575. DATE April 4, 1968		576. TIME 2:01 PM	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>75 Hammond Dr.</u>				d. STREET ADDRESS <u>75 Hammond Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jimmie</u> Middle <u>Lee</u> Last <u>Derrey</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-59</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>24</u> Min. <u>24</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Jimmie C. Derrey</u>				14. MOTHER'S MAIDEN NAME <u>Rosella Lee McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Rosella Derrey - Stuenkel</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed 3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>12-5-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		22d. LOCATION (City, town, or county) (State) <u>Laytonsville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>				ADDRESS <u>Laytonsville, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2073386X04



MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. EDUCATION	
9. RELIGION		10. RACE	
11. SOCIAL CLASS		12. PRESENT ADDRESS	
13. DATE OF DEATH		14. TIME OF DEATH	
15. PLACE OF DEATH		16. CAUSE OF DEATH	
17. MANNER OF DEATH		18. SIGNATURE OF EXAMINER	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF JURY	
21. SIGNATURE OF CORONER		22. SIGNATURE OF CLERK	
23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	
25. SIGNATURE OF JAILER		26. SIGNATURE OF DEPUTY JAILER	
27. SIGNATURE OF PRISONER		28. SIGNATURE OF DEPUTY PRISONER	
29. SIGNATURE OF GUARD		30. SIGNATURE OF DEPUTY GUARD	
31. SIGNATURE OF CHIEF OF POLICE		32. SIGNATURE OF DEPUTY CHIEF OF POLICE	
33. SIGNATURE OF SHERIFF		34. SIGNATURE OF DEPUTY SHERIFF	
35. SIGNATURE OF JAILER		36. SIGNATURE OF DEPUTY JAILER	
37. SIGNATURE OF PRISONER		38. SIGNATURE OF DEPUTY PRISONER	
39. SIGNATURE OF GUARD		40. SIGNATURE OF DEPUTY GUARD	
41. SIGNATURE OF CHIEF OF POLICE		42. SIGNATURE OF DEPUTY CHIEF OF POLICE	
43. SIGNATURE OF SHERIFF		44. SIGNATURE OF DEPUTY SHERIFF	
45. SIGNATURE OF JAILER		46. SIGNATURE OF DEPUTY JAILER	
47. SIGNATURE OF PRISONER		48. SIGNATURE OF DEPUTY PRISONER	
49. SIGNATURE OF GUARD		50. SIGNATURE OF DEPUTY GUARD	
51. SIGNATURE OF CHIEF OF POLICE		52. SIGNATURE OF DEPUTY CHIEF OF POLICE	
53. SIGNATURE OF SHERIFF		54. SIGNATURE OF DEPUTY SHERIFF	
55. SIGNATURE OF JAILER		56. SIGNATURE OF DEPUTY JAILER	
57. SIGNATURE OF PRISONER		58. SIGNATURE OF DEPUTY PRISONER	
59. SIGNATURE OF GUARD		60. SIGNATURE OF DEPUTY GUARD	
61. SIGNATURE OF CHIEF OF POLICE		62. SIGNATURE OF DEPUTY CHIEF OF POLICE	
63. SIGNATURE OF SHERIFF		64. SIGNATURE OF DEPUTY SHERIFF	
65. SIGNATURE OF JAILER		66. SIGNATURE OF DEPUTY JAILER	
67. SIGNATURE OF PRISONER		68. SIGNATURE OF DEPUTY PRISONER	
69. SIGNATURE OF GUARD		70. SIGNATURE OF DEPUTY GUARD	
71. SIGNATURE OF CHIEF OF POLICE		72. SIGNATURE OF DEPUTY CHIEF OF POLICE	
73. SIGNATURE OF SHERIFF		74. SIGNATURE OF DEPUTY SHERIFF	
75. SIGNATURE OF JAILER		76. SIGNATURE OF DEPUTY JAILER	
77. SIGNATURE OF PRISONER		78. SIGNATURE OF DEPUTY PRISONER	
79. SIGNATURE OF GUARD		80. SIGNATURE OF DEPUTY GUARD	
81. SIGNATURE OF CHIEF OF POLICE		82. SIGNATURE OF DEPUTY CHIEF OF POLICE	
83. SIGNATURE OF SHERIFF		84. SIGNATURE OF DEPUTY SHERIFF	
85. SIGNATURE OF JAILER		86. SIGNATURE OF DEPUTY JAILER	
87. SIGNATURE OF PRISONER		88. SIGNATURE OF DEPUTY PRISONER	
89. SIGNATURE OF GUARD		90. SIGNATURE OF DEPUTY GUARD	
91. SIGNATURE OF CHIEF OF POLICE		92. SIGNATURE OF DEPUTY CHIEF OF POLICE	
93. SIGNATURE OF SHERIFF		94. SIGNATURE OF DEPUTY SHERIFF	
95. SIGNATURE OF JAILER		96. SIGNATURE OF DEPUTY JAILER	
97. SIGNATURE OF PRISONER		98. SIGNATURE OF DEPUTY PRISONER	
99. SIGNATURE OF GUARD		100. SIGNATURE OF DEPUTY GUARD	



18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13894

## CERTIFICATE OF DEATH

Reg. Dist. No.

13836

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>5 Days 8 1/2 hr.</u>		d. STREET ADDRESS <u>17809 Boston Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ma E</u> Middle <u>T.</u> Last <u>Edwards</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-19-87</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Leonard Edwards</u>	
14. MOTHER'S MAIDEN NAME <u>Myra Travis</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Mrs. Wm. T. Lackland, 7809 Boston Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>401.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic fever</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>30 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>30 Dec 59</u> , 19 <u>59</u> , and that death occurred on <u>11:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9006 Glenville Rd 12/30/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>



31  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13893

CERTIFICATE OF DEATH

Reg. Dist. No.

13837

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2102 Dexter Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Eslin</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 26 1869</u>	
9. AGE (In years lost birthday) yrs. <u>90</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Michael J McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Sullivan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr Henry C Eslin</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Cerebral Vascular Accident</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. f. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> , to <u>Dec 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>59</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Lawrence Avery</u>				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John Lawrence Avery</u>				DATE SIGNED <u>12/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHN'S CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tallantree</u>				ADDRESS <u>3603 14th ST NW Wash DC</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

12222

Reg. No. 12222

1. NAME OF DECEASED Mary McLean		2. SEX Female		3. AGE 65		4. DATE OF BIRTH 1855	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Housewife		7. MARITAL STATUS Wife		8. DATE OF DEATH 1922	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MEDICAL HISTORY None		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF REGISTRAR J. H. Smith		14. SIGNATURE OF WITNESS J. H. Smith		15. SIGNATURE OF DECEASED None		16. SIGNATURE OF NEXT OF KIN J. H. Smith	
17. SIGNATURE OF DECEASED None		18. SIGNATURE OF NEXT OF KIN J. H. Smith		19. SIGNATURE OF DECEASED None		20. SIGNATURE OF NEXT OF KIN J. H. Smith	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF NEXT OF KIN J. H. Smith		23. SIGNATURE OF DECEASED None		24. SIGNATURE OF NEXT OF KIN J. H. Smith	
25. SIGNATURE OF DECEASED None		26. SIGNATURE OF NEXT OF KIN J. H. Smith		27. SIGNATURE OF DECEASED None		28. SIGNATURE OF NEXT OF KIN J. H. Smith	
29. SIGNATURE OF DECEASED None		30. SIGNATURE OF NEXT OF KIN J. H. Smith		31. SIGNATURE OF DECEASED None		32. SIGNATURE OF NEXT OF KIN J. H. Smith	
33. SIGNATURE OF DECEASED None		34. SIGNATURE OF NEXT OF KIN J. H. Smith		35. SIGNATURE OF DECEASED None		36. SIGNATURE OF NEXT OF KIN J. H. Smith	
37. SIGNATURE OF DECEASED None		38. SIGNATURE OF NEXT OF KIN J. H. Smith		39. SIGNATURE OF DECEASED None		40. SIGNATURE OF NEXT OF KIN J. H. Smith	
41. SIGNATURE OF DECEASED None		42. SIGNATURE OF NEXT OF KIN J. H. Smith		43. SIGNATURE OF DECEASED None		44. SIGNATURE OF NEXT OF KIN J. H. Smith	
45. SIGNATURE OF DECEASED None		46. SIGNATURE OF NEXT OF KIN J. H. Smith		47. SIGNATURE OF DECEASED None		48. SIGNATURE OF NEXT OF KIN J. H. Smith	
49. SIGNATURE OF DECEASED None		50. SIGNATURE OF NEXT OF KIN J. H. Smith		51. SIGNATURE OF DECEASED None		52. SIGNATURE OF NEXT OF KIN J. H. Smith	
53. SIGNATURE OF DECEASED None		54. SIGNATURE OF NEXT OF KIN J. H. Smith		55. SIGNATURE OF DECEASED None		56. SIGNATURE OF NEXT OF KIN J. H. Smith	
57. SIGNATURE OF DECEASED None		58. SIGNATURE OF NEXT OF KIN J. H. Smith		59. SIGNATURE OF DECEASED None		60. SIGNATURE OF NEXT OF KIN J. H. Smith	
61. SIGNATURE OF DECEASED None		62. SIGNATURE OF NEXT OF KIN J. H. Smith		63. SIGNATURE OF DECEASED None		64. SIGNATURE OF NEXT OF KIN J. H. Smith	
65. SIGNATURE OF DECEASED None		66. SIGNATURE OF NEXT OF KIN J. H. Smith		67. SIGNATURE OF DECEASED None		68. SIGNATURE OF NEXT OF KIN J. H. Smith	
69. SIGNATURE OF DECEASED None		70. SIGNATURE OF NEXT OF KIN J. H. Smith		71. SIGNATURE OF DECEASED None		72. SIGNATURE OF NEXT OF KIN J. H. Smith	
73. SIGNATURE OF DECEASED None		74. SIGNATURE OF NEXT OF KIN J. H. Smith		75. SIGNATURE OF DECEASED None		76. SIGNATURE OF NEXT OF KIN J. H. Smith	
77. SIGNATURE OF DECEASED None		78. SIGNATURE OF NEXT OF KIN J. H. Smith		79. SIGNATURE OF DECEASED None		80. SIGNATURE OF NEXT OF KIN J. H. Smith	
81. SIGNATURE OF DECEASED None		82. SIGNATURE OF NEXT OF KIN J. H. Smith		83. SIGNATURE OF DECEASED None		84. SIGNATURE OF NEXT OF KIN J. H. Smith	
85. SIGNATURE OF DECEASED None		86. SIGNATURE OF NEXT OF KIN J. H. Smith		87. SIGNATURE OF DECEASED None		88. SIGNATURE OF NEXT OF KIN J. H. Smith	
89. SIGNATURE OF DECEASED None		90. SIGNATURE OF NEXT OF KIN J. H. Smith		91. SIGNATURE OF DECEASED None		92. SIGNATURE OF NEXT OF KIN J. H. Smith	
93. SIGNATURE OF DECEASED None		94. SIGNATURE OF NEXT OF KIN J. H. Smith		95. SIGNATURE OF DECEASED None		96. SIGNATURE OF NEXT OF KIN J. H. Smith	
97. SIGNATURE OF DECEASED None		98. SIGNATURE OF NEXT OF KIN J. H. Smith		99. SIGNATURE OF DECEASED None		100. SIGNATURE OF NEXT OF KIN J. H. Smith	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

13896

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>181 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dean</b> Middle <b>(n)</b> Last <b>FARNSWORTH</b>				4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-22-02</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.	IF UNDER 24 HRS. <b>57</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Elmer Farnsworth</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Small</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		INFORMANT Address (Wife) <b>Ruth B. Farnsworth Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> 147X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA HYPOTHARYNX</b> DUE TO (c) <b>2 YEARS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 June</b> , 19 <b>59</b> , to <b>27 December</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>27 December</b> , 19 <b>59</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>12-28-59</b>							
ACTUAL SIGNATURE <b>George W. Taylor Sr.</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>G.W. TAYLOR CDR MC USN</b>				<b>U.S. Naval Hospital, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crementation</b>		22b. DATE THEREOF <b>12-28-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>1400 Chapin Street N.W. Washington</b>				24a. REC'D BY REGISTRAR <b>DEC-30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# DECLARATION OF DEATH

Deceased

Birth date

Place of birth

Married

Death date

Place of death

Signature

(Name of person making declaration)

Signature

Death date

Place of death

Signature

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1 X  
13897  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 4 Film G254 1-13-60 et  
CERTIFICATE OF DEATH

13839  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 626 South Stafford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Mary		Middle Leigh		Last FASER	
4. DATE OF DEATH December 23, 1959		Month 23		Day 23		Year 1959	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-59	
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Karl E. Faser		14. MOTHER'S MAIDEN NAME Mary Elizabeth SHANAHAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock and collapse 768.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia in the newborn DUE TO (c) Probably caused by maternal bacteremia		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 day 2 days		18. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 21 December, 1959 to 23 December, 1959, that I last saw the deceased alive on 23 December, 1959, and that death occurred at 3:00 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.	
21. ACTUAL SIGNATURE G.B. Avery		21. M.D. U.S. Naval Hospital, Bethesda Md. 12-23-59		21. DATE SIGNED U.S. Naval Hospital, Bethesda Md.		21. PHYSICIAN'S NAME (Type) G.B. Avery LT MC USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		23. ADDRESS R.A. Pumphrey 7557 Wisconsin, Ave. Bethesda Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knepp	

2051353XU4

DECLARATION OF INTEREST

U.S. Government, Washington, D.C.  
I, the undersigned, do hereby declare that I am not a member of, nor am I connected with, any organization, firm, or individual, which is known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government, and which are known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government.

U.S. Government, Washington, D.C.  
I, the undersigned, do hereby declare that I am not a member of, nor am I connected with, any organization, firm, or individual, which is known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government, and which are known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government.

U.S. Government, Washington, D.C.  
I, the undersigned, do hereby declare that I am not a member of, nor am I connected with, any organization, firm, or individual, which is known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government, and which are known to be engaged in the production, manufacture, sale, or distribution of goods or services which are subject to the control of the Federal Government.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13840

13898

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8606 Barron st</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>8606 Barron st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>David</u> Middle <u>Federman</u> Last <u></u>			<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>6</u> Year <u>1959</u>				
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>11-26-1890</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Stationery Supplies N.Y.C.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			<b>13. FATHER'S NAME</b> <u>Jacob Federman</u>				
<b>14. MOTHER'S MAIDEN NAME</b> <u>Rachael Federman</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				
<b>16. SOCIAL SECURITY NO.</b> <u>072-10-0076</u>			<b>17. INFORMANT</b> <u>Pauline Federman (wife)</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Notural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>12-6-59</u>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12/8-1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>mt Hope</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Hastings on the Hudson ny</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldberg Funeral Home Wash. D.C.</u>			<b>ADDRESS</b>				
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanes</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>710 Boundary Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Emily</u> Last <u>Field</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1959</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-8-58</u>		9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min. <u>59</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>Lawrence I Field</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Bisen</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mother</u>		Address <u>710-BOUNDARY AVE</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>475X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>12-24-59</u>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>				22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geedberg Funeral Home</u>				ADDRESS <u>4217-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 28 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13899

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>15 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3614 Sheppard St.</u>		e. STREET ADDRESS <u>3614 Sheppard St.</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick William Spletstoser</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Frederick Wm. Spletstoser</u>		14. MOTHER'S MAIDEN NAME <u>Eliz Fischer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #1</u>	
17. INFORMANT <u>Allice Fischer (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Blaschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLASCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>1/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Jackson, Michigan</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PIMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Jackson, Mississippi	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY	
1120 North 1st Street, Baltimore, Md.		Attorney		High School		Married		Catholic		Democratic	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORY OF PRESENT ILLNESS	
April 4, 1968		Baltimore, Md.		Heart Disease		Natural		Hypertension, Atherosclerosis		Chest pain, shortness of breath	
TIME OF DEATH		HOURS		MINUTES		TEMPERATURE		PULSE		BLOOD PRESSURE	
10:15 AM		10		15		98.6		60		160/90	
WEIGHT		HEIGHT		HAIR		EYES		SKIN		MOUTH	
170 lbs		5' 10"		Brown		Blue		Fair		No abnormalities	
TOOTH MARKS		FINGER MARKS		SCARS		TATTOOS		PREGNANT		LACTATING	
None		None		None		None		No		No	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE		HOURS		MINUTES	
J. Edgar Hoover		Attorney General		April 4, 1968		Baltimore, Md.		10		15	

13900

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lenganore</b> Middle <b>A.</b> Last <b>Fitzsimmons</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/76</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>8</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lenganore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. Boland</b>		14. MOTHER'S MAIDEN NAME <b>Emma G. Poole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes</b>	
INFORMANT <b>Mrs. H.H. Ramsdell, 3690 - 38th. St., N. W.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>581.0</b> DUE TO <b>Cirrhosis of liver</b> lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular renal disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-29</b> , 19 <b>59</b> , to <b>12-8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-8-59</b> , 19 <b>59</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris Perry</b>		ADDRESS (Street, city or town, state) <b>11602 Georgia Ave</b>	
PHYSICIAN'S NAME (Type) <b>Morris Perry</b>		DATE SIGNED <b>12-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Rose Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, R.F.D. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Haines</b>		ADDRESS <b>Gaithersburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one event within 72 hours after death.

CERTIFICATE OF DEATH

1922

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

RESIDENCE

DATE OF BIRTH

## CERTIFICATE OF DEATH

Reg. Dist. No.

13844

13901

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>19 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>4319 Reno Rd. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>O.</b> Last <b>Fowler</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/19/86</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>3</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lawyer</b>	
11. BIRTHPLACE (State or foreign country) <b>VILLA GROVE, ILL</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James M. Fowler</b>		14. MOTHER'S MAIDEN NAME <b>Laura Overman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT (Wife) Same as Above</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 332X DUE TO <b>Cerebral Vascular Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Hypertension - Arteriosclerosis Generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48-72 hrs</b> <b>7 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>55</b> , to <b>12-3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec. 3</b> , 19 <b>59</b> , and that death occurred at <b>8:38 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>P. P. Andrews</b>		ADDRESS (Street, city or town, state) <b>4201 FESSENDEN ST NW Washington D.C.</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>12-3-59</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/7/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Michigan City, Ind</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Ellis</b>		24a. REC'D BY REGISTRAR <b>DEC 7 '59</b>	
ADDRESS <b>Wisc. Ave. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1992

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

13845

13902

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>1/2 hr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Medical Center, Sandy Spring, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Dorothy Wyckoff Fraley</b>				4. DATE OF DEATH <b>12 29 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1.11.96</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>James Kinney</b>				14. MOTHER'S MAIDEN NAME <b>Violet Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>INFORMANT Address Hospital Records, Olney, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>1/2 hr</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/1</b> , 19 <b>59</b> , to <b>12.29.59</b> , that I last saw the deceased alive on <b>12.29.59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Center, Sandy Spring, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>C. H. Ligon, M. D.,</b> M.D. <b>Medical Center, Sandy Spring, Md.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Redland, Mont. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1911

NAME OF DECEASED  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
AGE  
SEX  
MARRIAGE  
EDUCATION  
OCCUPATION  
RELIGION  
BIRTH  
DEATH  
BURIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
13903  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

13849

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>1 day 17 hrs. 56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>4400 SIGSBEE ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PAUL A. FRANCESCO</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 24 1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 22, 1959</b>
9. AGE (In years last birthday) <b>0</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>17</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DOMINICK L. FRANCESCO</b>		14. MOTHER'S MAIDEN NAME <b>HELEN PATRICIA SCHUTZLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
INFORMANT Address <b>MRS. EVELYN TAUBER, 123 TALBOTT ST., ROCKVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple congenital anomalies of central nervous system defects</b> 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 22, 1959</b> to <b>Dec 24, 1959</b> that I last saw the deceased alive on <b>Dec 24, 1959</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>12020 Georgia Silver Spring, Md.</b> DATE SIGNED <b>12/25/59</b>			
ACTUAL SIGNATURE <b>Patrick C. Jameson</b> M.D.			
PHYSICIAN'S NAME (Type) <b>PATRICK C. JAMESON</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

2074 313XV4

13303

CERTIFICATE OF

INVESTIGATION OF HEALTH - RAILROAD

STATE OF NEW YORK

BEFORE ME

I day of

19

of the County of

STATE OF NEW YORK

COUNTY OF

CITY OF

JOHN J. HENNING

NOTARY

I hereby certify that

JOHN J. HENNING

is a resident of

the County of

and of the City of

and is qualified to

perform the duties of

Notary Public in and for

the State of New York.

In testimony whereof

I have hereunto set my hand

and the seal of my office

this day of

NOTARY PUBLIC IN AND FOR THE STATE OF NEW YORK

JOHN J. HENNING

My Commission Expires

NOTARY PUBLIC IN AND FOR THE STATE OF NEW YORK

JOHN J. HENNING

My Commission Expires

1

13904

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Beeche Grove foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rose Friedman</i>		4. DATE OF DEATH <i>Dec 5 1959</i>	
5. SEX <i>♀</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Hungary</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Hyman Friedman</i>		14. MOTHER'S MAIDEN NAME <i>Hanna Greenfeld</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Albert Rathner</i>		Address <i>6417 Kansas Ave NE DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>350X</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Parkinsonism</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>Yes</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/12</i> , 19 <i>59</i> , to <i>12/5</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12/4</i> , 19 <i>59</i> , and that death occurred at <i>7:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. H. Ligon</i>		ADDRESS (Street, city or town, state) <i>Sandy Spring, Md</i>	
PHYSICIAN'S NAME (Type) <i>C. H. Ligon</i>		DATE SIGNED <i>12/5/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/6-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>National Home Park Falls Church Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Goldberg Funeral Home Wash. DC</i>		24a. REC'D BY REGISTRAR <i>DATE DEC 8 '59</i>	
ADDRESS <i>Goldberg Funeral Home Wash. DC</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13847

Reg. Dist. No.

13905

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2238 Washington Ave - Apt 102</u>				d. STREET ADDRESS <u>2238 Washington Ave - Apt 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Harrison</u> Last <u>Frank</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1917</u>	
9. AGE (In years last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>		IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>P.O. Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles A. Frank</u>				14. MOTHER'S MAIDEN NAME <u>Alise Turney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>171-09-2223</u>		17. INFORMANT <u>Elaine Frank (wife)</u>		Address <u>Stem</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> (c) <u>sudden</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>12-15-59</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>12/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILLSIDE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FULLERTON, LEHIGH COUNTY, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zuck</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

## CERTIFICATE OF DEATH

Reg. Dist. No. 13848

13906

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>47X-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. 16 D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>5016 45th N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ching</u> Middle <u>Clay</u> Last <u>FUTR</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 15 1885</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Nicely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>57909-6061</u>		INFORMANT <u>Lawrence Kurr</u>		Address <u>5016 45th N.W. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Congestive Heart Failure</u> 48 hours DUE TO (c) <u>Hypertension Cardiovascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-26, 1959</u> , to <u>12-26, 1959</u> , that I last saw the deceased alive on <u>12-26, 1959</u> , and that death occurred at <u>8:37 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.P. Andrews</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>4201 Fessenden ST NW 12-26-1959</u>			
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS, M.D. Washington D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>DEAL FUNERAL HOME 4812 Ga Ave</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



13907

## CERTIFICATE OF DEATH

Reg. Dist. No.

13850

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Washington, D.C.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>88 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, NNMCM, Bethesda, Md.</u>				e. STREET ADDRESS <u>5215 Massachusetts Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Leslie Tracy GAGER</u>				4. DATE OF DEATH Month Day Year <u>December 25 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 27 1890</u>	
9. AGE (In years lost birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>	
13. FATHER'S NAME <u>John A. Gager</u>				14. MOTHER'S MAIDEN NAME <u>Luella Tracy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1st &amp; 2nd W.W.</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>Josephine C. Gager 5215 Mass Ave, W.D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (organism unknown)</u> 704.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia Follicular</u> DUE TO (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 28 1959</u> , to <u>December 25 1959</u> , that I last saw the deceased alive on <u>December 25 1959</u> , and that death occurred at <u>2:53 PM</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>U.S. Naval Hospital, Bethesda Md.</u> <u>12-26-59</u>							
ACTUAL SIGNATURE <u>James M. Young</u>				PHYSICIAN'S NAME (Type) <u>James M. YOUNG LT MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-28-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>De Vol Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be relieved by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1907

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

63 days

U.S. Naval Hospital, MED, Bethesda, Md. 20814, Washington Ave. N.W.

U.S. Naval Hospital, MED, Bethesda, Md. 20814, Washington Ave. N.W.

Male

Male

White

Age

Age

Medical Record

Medical Record

Medical Record

John A. Gager

John A. Gager

John A. Gager, W.H. (Unknown)

John A. Gager, W.H. (Unknown)

December 25

December 25

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington, D.C.

U.S. Naval Hospital, MED, Bethesda, Md. 20814, Washington Ave. N.W.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13833

CERTIFICATE OF DEATH

Reg. Dist. No. 13851

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. NAME OF DECEASED (Type or print) <i>Bertha</i> First <i>(NMN)</i> Middle <i>Garfinkel</i> Last				4. DATE OF DEATH Month <i>12</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-15-86</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Kontorsky</i>				14. MOTHER'S MAIDEN NAME <i>Libby</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>				16. SOCIAL SECURITY NO. <i>NONE</i>			
INFORMANT <i>Son</i>				Address <i>SAME AS ABOVE</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction due to coronary occlusion (left anterior descending branch)</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs. years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>12-14, 1959</i> to <i>12-16, 1959</i> that I last saw the deceased alive on <i>12-16, 1959</i> , and that death occurred at <i>9:20 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. M. Heiger</i>				ADDRESS (Street, city or town, state) <i>M.D. 931 Pershing Drive, Silver Spring, Md.</i>			
DATE SIGNED <i>12-16-59</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/17/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MT. CARMEL CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>BROOKLYN. N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Soldberg Funeral Home 4217 94th Ave</i>				24a. REC'D BY REGISTRAR <i>DC</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>DEC 21 '59</i>							

1995

13834 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 2,4,11 Film G254 12-30-59 et  
CERTIFICATE OF DEATH

GARFITT  
13852  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.C.</u> b. COUNTY <u>Orange County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>36 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Chapel Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sta + Hosp.</u>		d. STREET ADDRESS <u>1337 1/2 Rockshill Rd.</u> #1 Brandon Road	
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>Wighten</u> Middle <u>Garfitt</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7 - 1884</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Donald McGuire</u>	
14. MOTHER'S MAIDEN NAME <u>JANE Doctor</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Daughter:</u> <u>Mrs. Arthur Roe</u> Address <u>5357 Rockshill Rd. - Bethesda, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>578X</u> DUE TO <u>Renal Shutdown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Congestive Heart Failure due to Hypoproteinemia</u> (c) <u>Due to Malabsorption Syndrome Secondary to Gastroenteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 3</u> , 19 <u>59</u> to <u>December 9</u> , 19 <u>59</u> that I last saw the deceased alive on <u>December 9</u> , 19 <u>59</u> , and that death occurred at <u>340</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5800 BEECH AVE, BETHESDA, MD</u> DATE SIGNED <u>—</u>		
ACTUAL SIGNATURE <u>Edward Lewis Jr.</u> M.D.		
PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wynona Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Wynona, Nebraska</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Canal St NW DC.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13853

Reg. Dist. No.

13908

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mm</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7104 Delaware St</u>				d. STREET ADDRESS <u>7104 Delaware St</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Joseph A.</u> Middle <u>Yarguilo</u> Last <u>jr</u>				<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>10</u> Year <u>1959</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>10-9-1884</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>2</u> Days <u>1</u></td> <td>Hours <u>1</u> Min. <u>59</u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>2</u> Days <u>1</u>	Hours <u>1</u> Min. <u>59</u>
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months <u>2</u> Days <u>1</u>	Hours <u>1</u> Min. <u>59</u>						
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Trust Officer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Nat. Saving &amp; Trust Co</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. C.</u>				<b>13. FATHER'S NAME</b> <u>Joseph A. Yarguilo</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaretta Myer</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>577-03-4517</u>				<b>17. INFORMANT</b> <u>Clara Henley</u> Address <u>8516 Beach Tree Rd Bethesda</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> DUE TO (b) <u>gun shot wound -</u> DUE TO (c) <u>Head partially decapitated</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Refused to have an ill with C.A. of prostate with metastasis</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Head partially decapitated</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>					
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Valhalla N.Y.</u>		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify</b> that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>12-10-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>22b. DATE THEREOF</b> <u>12-12-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Kensico Cemetery</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Valhalla N.Y.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Joseph G. Gordiner, Inc. 1756 Pa. Ave. N.W. Washington, D. C.</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 14 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1908

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		Male		White		1863		Maryland	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
1000 N. E. Street		Carpenter		High School		Married		1885		1885	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
Jan 15, 1908		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
10:00 AM		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
Jan 15, 1908		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
10:00 AM		Home		Heart Disease		Natural		Coronary Artery Disease		Chest Pain, Shortness of Breath	

RECEIVED  
 JAN 16 1908  
 BALTIMORE, MD

## CERTIFICATE OF DEATH

Reg. Dist. No.

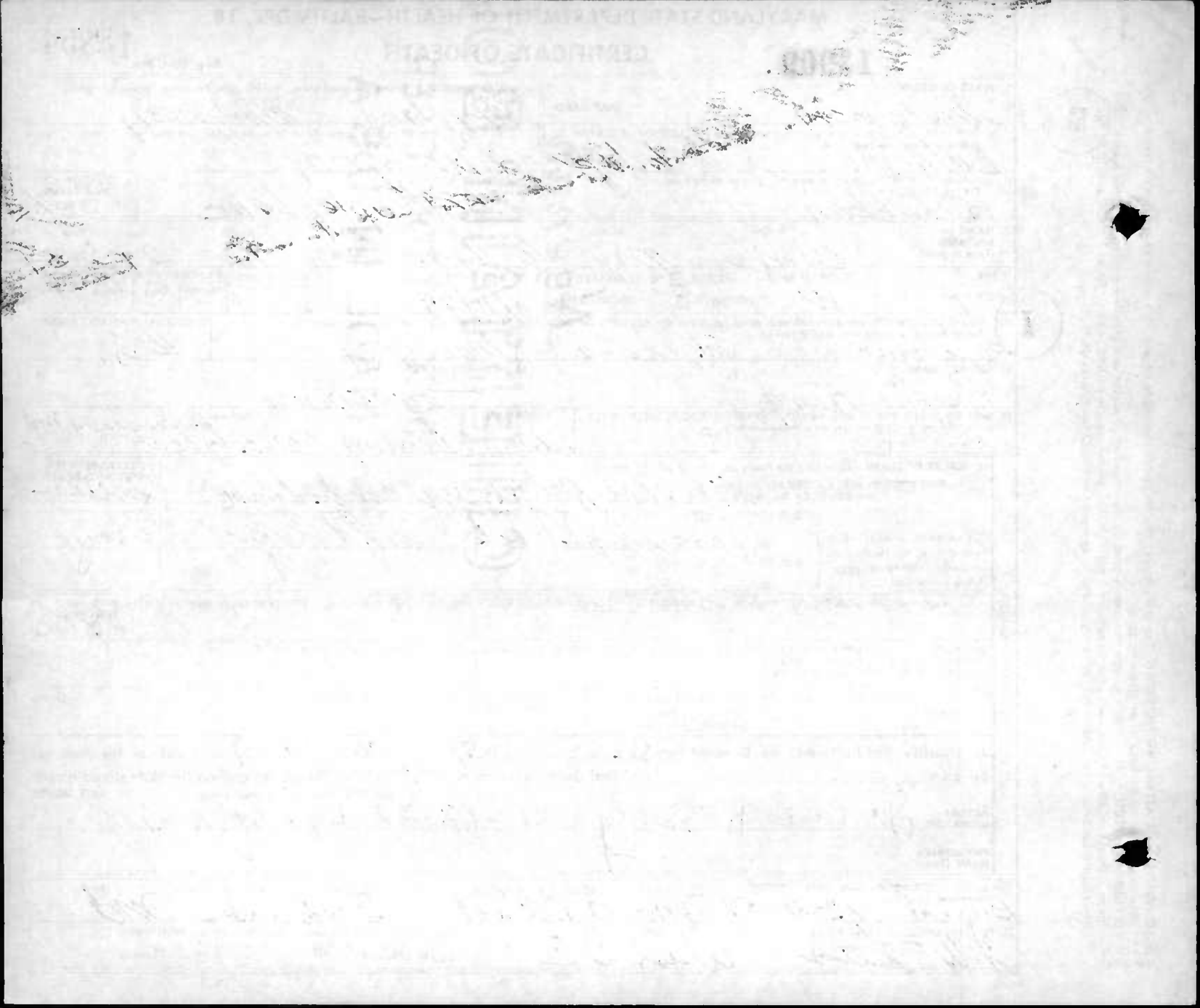
13854

13909

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie May Gooding</u>				4. DATE OF DEATH Month Day Year <u>12 27 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/99</u>	9. AGE (In years last birthday) yrs. <u>60</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Rufus King</u>				14. MOTHER'S MAIDEN NAME <u>— unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>P</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolism</u> <u>463X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Thrombophlebitis, left leg</u> DUE TO (c) <u>8 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Dec 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>943</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Sully</u> M.D.				ADDRESS (Street, city or town, state) <u>1835 Eye St NW</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>J</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-31-59</u>		<u>Mount Olivet</u>		<u>Fredrick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. W. Lee - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13855

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>#2 Alsace Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>S.</b> Last <b>Gospodarek</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 5, 1959</b>
9. AGE (In years last birthday) yrs. <b>2</b> Months <b>3</b> Days <b>3</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Francis S. Gospodarek</b>		14. MOTHER'S MAIDEN NAME <b>Mary P. Brosnan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Francis S. Gospodarek-father-same as 2d</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Upper respiratory infection</b> DUE TO (c) <b>Found dead in bed</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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11 FROM THE WITH-TO TOWNSHIP OF CHARTER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13856

13910

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>71 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Patrick Air Force Base 48X-3</b> d. STREET ADDRESS <b>1031 D ALA</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Steffens GRAFF</b>				4. DATE OF DEATH Month Day Year <b>December 16 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-01</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph H. GRAFF</b>				14. MOTHER'S MAIDEN NAME <b>Helen L. STEFFENS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I and II</b>		INFORMANT <b>(Wife) Mildred C. Graff</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>162.1</b> DUE TO <b>with metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that I attended the deceased from <b>6 October 1959</b> to <b>16 December 1959</b> , that I last saw the deceased alive on <b>16 December 1959</b> , and that death occurred at <b>10:25AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 12-16-59</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Douglas R. Koth</b> PHYSICIAN'S NAME (Type) <b>D.R. KOTH LCDR MC USN</b>				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				24. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13835

CERTIFICATE OF DEATH

Reg. Dist. No.

13857

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Summit</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. LENGTH OF STAY IN 1b <u>44 yrs 10 mo 5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Summit</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San &amp; Hospital</u>				d. STREET ADDRESS <u>Suburban Hotel</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>E. Norma R. Graham</u>				4. DATE OF DEATH Month Day Year <u>12 5 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-8-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known by hosp.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>	
13. FATHER'S NAME <u>MARCUS PURCELL</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Proctor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>pt Chas O' Wash San &amp; Hosp.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-day</u> <u>? years</u> <u>? years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-2-59</u> to <u>12-5-59</u> , that I last saw the deceased alive on <u>12-2-59</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Tak. Park, Md.</u>		DATE SIGNED <u>12/5/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>12/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Jackson Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Lexington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines co</u>				ADDRESS <u>2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1907

CERTIFICATE OF DEATH

1883



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13911

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>13502 Grenoble Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>JANE</u> Last <u>GRANZOW</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK O. Shrodes</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL McCARTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u>579-18-7615</u>		INFORMANT <u>Richard GRANZOW</u> Address <u>Husband same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 170x DUE TO <u>Statin postoperative-Guinea left Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radiation pneumonitis left lung</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-11</u> , 19 <u>58</u> , to <u>12-4</u> , 19 <u>59</u> that I last saw the deceased alive on <u>12-4</u> , 19 <u>59</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah E. Glover</u>				ADDRESS (Street, city or town, state) <u>10128 CEDAR LAKE NEWINGTON, MD</u>			
DATE SIGNED <u>12-5-59</u>							
PHYSICIAN'S NAME (Type) <u>SARAH E GLOVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fork Lissen</u>		22d. LOCATION (City, town, or county) (State) <u>Polmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u> ADDRESS <u>Mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1938

CERTIFICATE OF DEATH

1938

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased: FRANK C. SHAW

2. Sex: Male

3. Age: 45

4. Date of birth: 1900

5. Date of death: 1938

6. Place of death: At home

7. Cause of death: Heart disease

8. Signature of physician: Dr. J. H. Smith

9. Signature of registrar: John D. Jones

10. Date of registration: 1938

13912

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Perry</b> Last <b>Griffith</b>				4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/17/79</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>23</b>		IF UNDER 24 HRS. Hours <b>23</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard H. Perry</b>				14. MOTHER'S MAIDEN NAME <b>XXXXX Margaret Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Mrs. J. H. Littlepage, 8612 Ridge Rd., Beth.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cerebrovascular Accident</b> 331X DUE TO <b>cerebral arteriosclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>X</b> (c) <b>X</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 5, 1959</b> to <b>Dec. 10, 1959</b> , that I last saw the deceased alive on <b>Dec. 10, 1959</b> , and that death occurred at <b>250 M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George A. Gray, Jr.</b>				ADDRESS (Street, city or town, state) <b>4422 East-West Hwy, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>George A. GRAY, JR. M.D.</b>				DATE SIGNED <b>12/10/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 14 '59</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thaw</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1942

CERTIFICATE OF DEATH

STATE OF CALIFORNIA



*[Faint, mostly illegible text from the reverse side of the document, including names and dates.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13860

13836

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DISTRICT OF COLUMBIA</b> h. COUNTY <b>47X-3</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK, MARYLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, DISTRICT OF COLUMBIA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>700-HUDSON AVENUE-EVENTIDE NURSING HOME</b>		d. STREET ADDRESS <b>615-UNDERWOOD STREET, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>DORA</b> Middle <b>M.</b> Last <b>HAACK</b>		4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>19th</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 30, 1878</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE - AT HOME</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	9. AGE (In years last birthday) <b>81</b> yrs.
10. FATHER'S NAME <b>August Brasa</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. MOTHER'S MAIDEN NAME <b>Doris Elhardt</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT (SON) <b>MR. FRED J. HAACK</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>7 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1952</b> , to <b>Dec 19, 1959</b> , that I last saw the deceased alive on <b>Dec 8, 1959</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M.F. OTTMAN</b>		ADDRESS (Street, city or town, state) <b>401-Kennedy St NW Wash DC</b>	
PHYSICIAN'S NAME (Type) <b>M.F. OTTMAN</b>		DATE SIGNED <b>12/20/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL</b>
22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>		22e. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>MARTIN W. HYSONG</b>		COMPANY <b>COMP</b>	
ADDRESS <b>1300-N. ST, N.W.-WASHINGTON, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

CERTIFICATE OF DEATH

1938

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		MARRIAGE Married	
DATE OF DEATH April 15, 1938		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
DECEASED'S RESIDENCE 1234 North Avenue		DECEASED'S OCCUPATION Retired		DECEASED'S BIRTH DATE April 15, 1873		DECEASED'S BIRTH PLACE Baltimore, Md.		DECEASED'S BIRTH STATE Maryland	

CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		INTERMEDIATE CAUSE Coronary Artery Disease		FINAL CAUSE Atherosclerosis	
DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

DECEASED'S PREVIOUS ILLNESS Hypertension		DECEASED'S PREVIOUS SURGERY None		DECEASED'S PREVIOUS TRAUMA None		DECEASED'S PREVIOUS INFECTION None		DECEASED'S PREVIOUS TOXICITY None	
DECEASED'S PREVIOUS ALCOHOLISM None		DECEASED'S PREVIOUS DRUGS None		DECEASED'S PREVIOUS RADIATION None		DECEASED'S PREVIOUS OTHER CAUSES None		DECEASED'S PREVIOUS OTHER CAUSES None	

Reg. Dist. No. 13861

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4005 Underwood St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Albaugh</b> Last <b>Hale</b>		4. DATE OF DEATH Month <b>December</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1862</b>
9. AGE (In years last birthday) yrs. <b>97</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Albaugh</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Mendenhall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Sarah Sutton</b>		Address <b>4005 Underwood St. Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chronic myocarditis</b> DUE TO lying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Over 30 y</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 21, 1947</b> to <b>Dec. 27, 1959</b> , that I last saw the deceased alive on <b>Dec. 27, 1959</b> , and that death occurred at <b>12:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Katharine A. Chapman</b> M.D. <b>3924 Baltimore St.</b>		PHYSICIAN'S NAME (Type) <b>Katharine A. Chapman, M.D. Kensington, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans. Bur.</b>		22b. DATE THEREOF <b>12/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Milton cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West Milton, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 30 1959</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Thompson		DATE OF DEATH December 21, 1952	
AGE 45 years		SEX Male	
RACE White		BIRTH DATE July 1, 1907	
BIRTH PLACE Baltimore, Md.		RESIDENCE 1005 Underwood St., Baltimore, Md.	
OCCUPATION Salesman		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
EDUCATION High School		RELIGION Roman Catholic	
MARRIAGE Married		SPOUSE Mary Thompson	
CHILDREN None		PREVIOUS ILLNESS None	
DATE OF BIRTH July 1, 1907		DATE OF DEATH December 21, 1952	
PLACE OF BIRTH Baltimore, Md.		PLACE OF DEATH Home	
OCCUPATION Salesman		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		PLACE OF DEATH Home	
EDUCATION High School		RELIGION Roman Catholic	
MARRIAGE Married		SPOUSE Mary Thompson	
CHILDREN None		PREVIOUS ILLNESS None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13914

## CERTIFICATE OF DEATH

Reg. Dist. No.

13862

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>X BETHESDA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lilian</u> Middle <u>DEARY</u> Last <u>HAMILTON</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-21-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min.	11. IF UNDER 24 HRS. Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BRITISH EMBASSY</u>	
11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>	
13. FATHER'S NAME <u>HENRY DEARY ROSS</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN CATHARINE GODFREY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>SHIRLEY D. TANNER - 5919 ANNISTON RD.</u>	
17. INFORMANT (NIECE) <u>SHIRLEY D. TANNER</u>		Address <u>BETHESDA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis, metastatic to liver</u> 153.0 DUE TO <u>Carcinoma of cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of cecum</u> DUE TO (c) <u>Carcinoma of cecum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>December 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 7</u> , 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Kurtz</u> M.D.		ADDRESS (Street, city or town, state) <u>3701 Conn Ave. NW</u> DATE SIGNED <u>12-7-59</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz, M.D.</u>		<u>Wash. 8, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit 12/11/59</u>		22b. DATE THEREOF <u>12/11/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Hills Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Toronto, Canada</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



CERTIFICATE OF DEATH

1911

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

Vertical text on the right margin, possibly a date or reference number, oriented vertically.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13863

13915

Item 7 Film 0253 12-17-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

MONTGOMERY

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda Naval Hosp

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

3V01-4

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Bethesda Naval Hosp.

d. STREET ADDRESS

8 W. Jeffery Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

Eddie

Roy

Harris

## 4. DATE OF DEATH

Dec. 9

Month

Day

Year

19 59

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## 8. DATE OF BIRTH

8/25/1907

## 9. AGE (In years last birthday)

52 yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Welder

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

Robert Harris

## 14. MOTHER'S MAIDEN NAME

Bessie Rogers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Family

Address

Same

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.1

DUE TO

Coronary occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH  
5 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour o. m. p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

John G. Ball

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

John G. Ball

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

9 Dec. 1959

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

12/13/59

22c. NAME OF CEMETERY OR CREMATORY

Oakwood Cem.

22d. LOCATION (City, town, or county)

Siler City, N.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

McCully Funeral Homes 130 E. Fort Ave.

24a. REC'D BY REGISTRAR

DATE DEC 11 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		Maryland		1918		10:00 AM		Home		Heart Disease		Natural		J. Doe, M.D.		10/18/18	
PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
Maryland		1873		Male		White		Roman Catholic		Married		High School		Teacher		Maryland		1918		10:00 AM		Home		Heart Disease		Natural		J. Doe, M.D.		10/18/18	
PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
Maryland		1873		Male		White		Roman Catholic		Married		High School		Teacher		Maryland		1918		10:00 AM		Home		Heart Disease		Natural		J. Doe, M.D.		10/18/18	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13916

CERTIFICATE OF DEATH

Reg. Dist. No.

13864

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>4916 35th Street, North</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Stone Haseltine</u>				4. DATE OF DEATH Month Day Year <u>December 1 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 July 1947</u>	
9. AGE (In years lost birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Nathan S. Haseltine</u>				14. MOTHER'S MAIDEN NAME <u>Emily Clevonger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>The Medical Record</u>				<u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>224X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Pheochromocytoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 4, 1959</u> , to <u>December 1, 1959</u> that I last saw the deceased alive on <u>December 1, 1959</u> , and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12/1/59</u>							
ACTUAL SIGNATURE <u>Louis Gillespie Jr.</u>				M.D. <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>Louis Gillespie Jr. M.D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>12-4-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>				22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home</u> ADDRESS <u>2847 Wilson Blvd., Arlington, Va.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>			
By: <u>C. M. Trammel</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tramm</u>			

2

050

1

1

12345

1

Received of the Treasurer of the United States  
the sum of \$100.00

for the purchase of 100 shares of United States Steel Corporation

at the price of \$1.00 per share

on the 1st day of January 1912

for the account of the United States Steel Corporation

and for the account of the United States Steel Corporation  
the sum of \$100.00

for the purchase of 100 shares of United States Steel Corporation

at the price of \$1.00 per share

on the 1st day of January 1912

for the account of the United States Steel Corporation

the sum of \$100.00

for the purchase of 100 shares of United States Steel Corporation

at the price of \$1.00 per share

on the 1st day of January 1912

for the account of the United States Steel Corporation

the sum of \$100.00

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

13865

13917

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>319 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Martha</b> Last <b>HECK</b>				4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-94</b>	
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John HECK</b>				14. MOTHER'S MAIDEN NAME <b>Sarah LOGUE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>WW II</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, breast &amp; generalized metastases</b> 170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>21 January</b> , 19 <b>59</b> , to <b>6 December</b> , 19 <b>59</b> that I last saw the deceased alive on <b>6 December</b> , 19 <b>59</b> and that death occurred at <b>5:06</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 12-7-59</b>			
PHYSICIAN'S NAME (Type) <b>D.P. OSBORNE CAPT MC USN</b>				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>				22e. (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Gawlers</i> <b>Joseph Gawlers 1756 Penn. Ave. N.W. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1941

Division of Statistics

Washington, D.C.

Washington, D.C.

312 days

Rechnung (No. 1)

3123 0000. Ave. Kennedy, N.Y.

U.S. Naval Hospital, Bethesda Md.

December

1941

Rechnung

Rechnung

12

3-27-41

Rechnung

Rechnung

U.S.

Rechnung

U.S. Government

U.S. Navy

Rechnung

Rechnung

(Rechnung) Klaus H. Hildebrand

Rechnung

Rechnung

31 December

Rechnung

Rechnung

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Washington, D.C.

Washington, D.C.

Rechnung

Rechnung

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13866

Reg. Dist. No.

13918

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8300 Tilbury Street</b>				d. STREET ADDRESS <b>8300 Tilbury St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>HAROLD C. HEIGHAM</b>				4. DATE OF DEATH Month Day Year <b>Dec. 3, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1904</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William H. Heigham</b>				14. MOTHER'S MAIDEN NAME <b>Ella A. Ittner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Wife Sarah M. Heigham</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				24a. REC'D BY REGISTRAR <b>DEC 7 59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanks</i>	
ADDRESS <b>Bethesda, Md.</b>				DATE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		DATE OF BIRTH [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]	
MARITAL STATUS [REDACTED]		COLOR [REDACTED]	
PRESENT ADDRESS [REDACTED]		DATE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
DATE OF EXAMINATION [REDACTED]		PLACE OF EXAMINATION [REDACTED]	

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13867

13519

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE [Where deceased lived. If institution; Residence before admission] o. STATE <b>Md.</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Md.</b>		c. LENGTH OF STAY IN 1b <b>11½ hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montg. County Gen. Hosp. Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle <b>August</b> Last <b>Heine</b>		4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/87</b>
9. AGE (In years last birth day) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>18</b> Hours <b>19</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Govt. Clerk-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Gotleib Heine</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>825X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thoracic hemorrhage</b> DUE TO (c) <b>Crushed chest</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car involved in auto accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:52 p. m. 12, 17, 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Fulton Howard Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Dec 21, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		24a. RECEIVED BY REGISTRAR <b>DEC 21 '59</b>	
ADDRESS <b>254 Carroll St NW DC</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 45		DATE OF BIRTH 10/15/1907		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Police Officer		MARITAL STATUS Single		COLOR White		HEIGHT 5' 8"		WEIGHT 175	
CAUSE OF DEATH Hemorrhage		MANNER OF DEATH Accidental		PLACE OF DEATH Baltimore, Md.		TIME OF DEATH 10:30 PM		DATE OF DEATH 12/18/52	
SIGNATURE OF EXAMINER J. H. HARRIS		SIGNATURE OF DECEASED J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	
SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF WITNESS J. H. HARRIS	

12/18/52

13920

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DC</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9301 Weaver Street</b> <b>The Althea Woodland Nursing Home</b>		d. STREET ADDRESS <b>1661 Harvard Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Milton</b> Middle <b>Herman</b> Last <b>Herman</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/79</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Wear</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Herman</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Fishman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
INFORMANT Address <b>Home Records - 9301 Weaver Street</b> <b>Silver Spring, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>several years</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>331X</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Former Hemiplegia Oct 1958</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1959</b> to <b>Dec 9 1959</b> , that I last saw the deceased alive on <b>Dec 8 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9601 Colesville Rd</b> DATE SIGNED <b>Dec 9-59</b> ACTUAL SIGNATURE <b>John N. Andrews</b> M.D. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b> <b>Silver Spring Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/9/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE <b>DEC 10 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



DEPARTMENT OF HEALTH

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U.S. DEPT. OF HEALTH

John H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13869

13837

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>8625 Piney Branch Rd.,</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hester</u>		4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-59</u>
9. AGE (In years lost birthday) yrs. <u>35</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Hester, William C.</u>		14. MOTHER'S MAIDEN NAME <u>Hester Marian Louise</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 23 wks. gestation</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9:25 AM, 1959</u> , to <u>9:50 AM, 1959</u> , that I last saw the deceased alive on <u>12-13</u> , 1959, and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Emma Hughes</u>		M.D. <u>Washington Sanitarium and Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M. D. Washington Sanitarium and Hospital</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>12-14-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital Takoma Park, Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D.</u>		ADDRESS <u>Washington Sanitarium and Hosp. Takoma Park, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15M 9/55

DEC 16 '59

C. S. H. Hare

2175211X40

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

5285

## CERTIFICATE OF DEATH

Reg. Dist. No.

13870

13838

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u> c. LENGTH OF STAY IN lb <u>51 Hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sanatorium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Silver Spring</u> d. STREET ADDRESS <u>12127 Georgia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizabeth</u> Last <u>Hoback</u>		4. DATE OF DEATH Month <u>12</u> Day <u>-</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-22-12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mountain Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
13. FATHER'S NAME <u>Harry D. Spangler</u>		14. MOTHER'S MAIDEN NAME <u>Lottie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>essential hypertension</u> DUE TO (c) <u>Cerebral hemorrhage</u> <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September, 1959</u> , to <u>Dec 1, 1959</u> , that I last saw the deceased alive on <u>Dec 1</u> , 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Patrick C Jameson</u> M.D.		ADDRESS (Street, city or town, state) <u>12020 Georgia</u>	
PHYSICIAN'S NAME (Type) <u>PATRICK C JAMESON</u>		DATE SIGNED <u>12/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Waynesboro Franklin Co., Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Grove</u>		ADDRESS <u>Waynesboro Pa</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	
DATE <u>DEC 3 '59</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



RECEIVED  
FEB 11 1911  
U. S. DEPT. OF AGRICULTURE  
WASHINGTON, D. C.

13338

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13871

13921

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>			c. LENGTH OF STAY IN 1b <b>5 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Park, Md. 16X-2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>				d. STREET ADDRESS <b>4629 Davis avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b> First Middle Last				4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>?</b>	
9. AGE (In years last birthday) <b>80 ? yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Maybell Gall Bradbury Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> 788.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hyper pyrexia, Unknown Cause</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>36 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>Dec 20, 1959</b> , that I last saw the deceased alive on <b>Dec 20</b> , 19 <b>59</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>Dec 21, 1959</b> ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D. <b>Kensington, Md.</b> PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D. Kensington, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/23/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>				24a. REC'D BY REGISTRAR DATE <b>Dec 22 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13872

13922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>56</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9806 Forest Grove Drive</b>				d. STREET ADDRESS <b>9806 Forest Grove Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Lula</b> Last <b>Hodge</b>				4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1959</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. <del>MARRIED</del> <input checked="" type="checkbox"/> <del>NEVER MARRIED</del> <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <del>DIVORCED</del> <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 17, 1878</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Ivan Renfrow</b>				14. MOTHER'S MAIDEN NAME <b>Cora Ann Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>No</b>			
17. INFORMANT <b>Alga Hodge</b>				Address <b>1601 Argonne Pl NW- DC</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>General arteriosclerosis</b> DUE TO (c) <b></b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>4-5 year.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-12</b> , 19 <b>59</b> , to <b>12-31</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-30</b> , 19 <b>59</b> , and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W.B. Wardrop M.D.</b>				ADDRESS (Street, city or town, state) <b>800 Pershing Drive Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>W.B. Wardrop</b>				DATE SIGNED <b>12/31/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>1/1/1960</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Maplewood</b>				22d. LOCATION (City, town, or county) (State) <b>Wilson, North Carolina</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>DATE JAN 4 '60</b>			
ADDRESS <b>Washington 9, D.C.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

MEDICAL CERTIFICATION

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13873

Reg. Dist. No.

13923

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bluesy</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Monty Co. Gen. Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Holland</u> <u>13x-2</u> d. STREET ADDRESS <u>Heels Shop Rd</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Eli</u> Middle <u>Hottinger</u> Last <u></u>				<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>20</u> Year <u>1959</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-14-1891</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>labourer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Landscape</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>va</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220 32 6658</u>				<b>17. INFORMANT</b> <u>Bendah Hottinger</u> Address <u>Illus 2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>421.4 Acute Myocarditis</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <u>Chronic Coronary Heart Disease</u>            DUE TO <b>(c)</b> <u></u> </p> </div> <div style="width: 15%;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>1 1/2 hrs</u>  <u>years</u> </p> </div> </div>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b>							
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>12-20-59</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Dec. 23 '59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Lukes</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Redland</u> <u>Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Roy W Barber</u> <b>ADDRESS</b> <u>Laytonsville, Md</u>						<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Christina S. Hume</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10021

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH MEDICAL HISTORY PRESENT ILLNESS TREATMENT POST-MORTEM SIGNATURE OF EXAMINER DATE PLACE TITLE SIGNATURE OF REGISTRAR DATE PLACE TITLE	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13924

CERTIFICATE OF DEATH

Reg. Dist. No.

13874

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSP</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FLORENCE VIRGINIA HOTTINGER</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 25 19 59</b>			
5. SEX <b>F. MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/2/ 1889</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>LEVI -Brady</b>				14. MOTHER'S MAIDEN NAME <b>SUSAN -- Whitecotton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>			
17. INFORMANT <b>HOSPITAL RECORDS</b>				Address <b>OLNEY, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Thrombosis (cerebral)</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerosis, generalized, severe</b> DUE TO (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension essential; Subacute urinary infection</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>OLNEY</b>				20g. (County) <b>MONTGOMERY</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>January 1955</b> to <b>December 25 1959</b> that I last saw the deceased alive on <b>Dec 25</b> , 19 <b>59</b> , and that death occurred at <b>10:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DAMASCUS, MARYLAND</b> DATE SIGNED <b>12/26/59</b>							
ACTUAL SIGNATURE <b>G. F. Meadors</b>				M.D. <b>G. F. MEADORS, M. D.</b>			
PHYSICIAN'S NAME (Type) <b>G. F. MEADORS, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Dec. 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill</b>	
22d. LOCATION (City, town, or county) <b>Redland, Mont., Md.</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 31 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. S. H. H.</b>				24c. DATE <b>DEC 31 '59</b>			



STATE OF MONTANA

1908

DEPARTMENT OF

MINES

MINING ACTS

RECORDS

1908

STATE OF MONTANA

RECORDS

DEPARTMENT OF

MINES

MINING ACTS

RECORDS

13839

## CERTIFICATE OF DEATH

Reg. Dist. No. 13875

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Mass. D.C.</i> b. COUNTY <i>✓</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salem Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>47X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hosp</i>				d. STREET ADDRESS <i>5442 Kansas Ave. NW.</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Lee</i> Last <i>Houk Jr.</i>				4. DATE OF DEATH Month <i>12</i> Day <i>20</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-25-98</i>	
9. AGE (In years lost birthday) <i>61</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U.S. Post Office Dept</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>St. Va</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>							
13. FATHER'S NAME <i>Harry Lee Houk</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Lemen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>✓</i> (If yes, give war or dates of service) <i>World Army</i>				16. SOCIAL SECURITY NO. <i>pt Chas</i>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X Carcinoma of Prostate</i> DUE TO (b) <i>4 years</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <i>177X</i> DUE TO (b) <i>4 years</i> DUE TO (c) <i>177X</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>177X</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>8/12</i> , 19 <i>47</i> , to <i>12-20-59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>12-20-59</i> , 19 <i>59</i> , and that death occurred at <i>7:40 P.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Arthur S. Kraus</i>				M.D. <i>113 Carroll St NW Wash DC</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-23-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i>				ADDRESS <i>4812 Ga Ave NW DC</i>		24a. REC'D BY REGISTRAR <i>DEC 28 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2551

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13926

CERTIFICATE OF DEATH

Reg. Dist. No.

13876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>51 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>4 Saint Agnes Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Okema</u> Middle <u>May</u> Last <u>Huffman</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1951</u>	
9. AGE (In years lost birthday) yrs. <u>8</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Otuce Huffman</u>				14. MOTHER'S MAIDEN NAME <u>Orada Bostic</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>			
INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal Hemorrhage</u> DUE TO <u>204.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Acute Lymphatic Leukemia</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 2, 1959</u> to <u>December 23, 1959</u> that I last saw the deceased alive on <u>December 23, 1959</u> , and that death occurred at <u>1:25 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Mengel</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12-23-59</u>			
PHYSICIAN'S NAME (Type) <u>Charles E. Mengel, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>				24b. REGISTRAR'S SIGNATURE <u>C. L. S. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13091

The Medical Officer, Northampton,  
do hereby certify that Robert A. Humphrey,  
aged 35 years,  
died on 12/24/00 at Northampton, Massachusetts.

Witness my hand and the seal of the Registrar of Vital Statistics,  
at Northampton, this 25th day of December, 1900.

Robert A. Humphrey  
Registrar of Vital Statistics

Robert A. Humphrey  
Physician

Robert A. Humphrey  
Physician

Robert A. Humphrey  
Physician

Robert A. Humphrey  
Physician

Robert A. Humphrey  
Physician

Robert A. Humphrey  
Physician

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13877

13926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>DOA</u>				d. STREET ADDRESS <u>6806 Granby Dr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USNH, NMHC, BETHESDA, MD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT L. HULLINGHORST</u>				4. DATE OF DEATH <u>Dec 10 19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Sept-9-1916</u>		9. AGE (In years last birthday) <u>43</u> yrs.	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col MC USA</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U S Army</u>		11. BIRTHPLACE (State or foreign country) <u>TELA-HONDURAS</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>GEORGE J. HULLINGHORST</u>				14. MOTHER'S MAIDEN NAME <u>ROSA WARREN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1934-1959</u>				16. SOCIAL SECURITY NO. <u>212-38-8033</u>		17. INFORMANT <u>JEAN I HULLINGHORST</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael J. Rinaldi</u> ADDRESS <u>816 H St., N. E. Washington 2, D. C.</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED</p>		<p>DATE OF DEATH</p>	
<p>AGE</p>		<p>SEX</p>	
<p>RESIDENCE</p>		<p>PLACE OF DEATH</p>	
<p>CAUSE OF DEATH</p>		<p>MANNER OF DEATH</p>	
<p>DATE OF EXAMINATION</p>		<p>TIME OF EXAMINATION</p>	
<p>SIGNATURE OF EXAMINER</p>		<p>DATE</p>	

13927

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charlotte</b> Middle <b>(None)</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1926</b>	
9. AGE (In years last birthday) <b>33</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Housewife)</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David L. Alpert</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Stein</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>P Respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive pulmonary infiltration and hemothorax</b> DUE TO (c) <b>Malignant melanoma</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>minutes</b> <b>days</b> <b>22 months</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 19, 1959</b> to <b>December 10, 1959</b> that I last saw the deceased alive on <b>December 10, 1959</b> , and that death occurred at <b>3:05 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>12-10-59</b>							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M. D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>DEC. 11, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS - 3501-14th St. N.W.</b>				24a. RECEIVED BY REGISTRAR <b>DEC 14 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13563

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>life</u>				d. STREET ADDRESS <u>18913 Brookville Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8913 Brookville Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Margaret Henderson James</u> First Middle Last				4. DATE OF DEATH <u>Dec 7 1959</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-9-26</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James A Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry James</u> Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left breast with</u> DUE TO <u>Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c) <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (specify) <u>Buried</u>		22b. DATE THEREOF <u>12/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial.</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Sworde</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13880

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17302 Takoma Park</i> d. STREET ADDRESS <i>Patterson Court</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>LEOKADIA</i> Middle <i>JASHEMSKI</i> Last <i>JASHEMSKI</i>		4. DATE OF DEATH Month <i>Dec.</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 1, 1888</i>
9. AGE (In years lost birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min. <i>1</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Radziejowski</i>		14. MOTHER'S MAIDEN NAME <i>Marya</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Stanley A. Jaschewski; 415 Peachy M. St. Md.</i>	
17. INFORMANT <i>Stanley A. Jaschewski; 415 Peachy M. St. Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Severe generalized arteriosclerosis</i> DUE TO (c) <i>10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>22 December 1959</i> , to <i>23 December 1959</i> , that I last saw the deceased alive on <i>22 December, 1959</i> , and that death occurred at <i>6:40 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Russell B. Arnold</i>		ADDRESS (Street, city or town, state) <i>5801 Colesville Road, MD</i> DATE SIGNED <i>23 Dec '59</i>	
PHYSICIAN'S NAME (Type) <i>Russell B. Arnold M.D., Silver Spring, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 26, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>York, Nebraska</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St NW DC</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24. REC'D BY REGISTRAR <i>DEC 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Francis</i>	



CERTIFICATE OF DEATH

Married  
John H. Jones  
1901

John H. Jones

John H. Jones

John H. Jones  
1901

John H. Jones  
1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13930 Item 1 Film G253 12-14-59 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

13881

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5821-Bradley Blvd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5821 Bradley Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>MAY</u> Last <u>JENKINS</u>		4. DATE OF DEATH Month <u>December</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1-1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		12. KIND OF BUSINESS OR INDUSTRY <u>DRESS SHOP</u>	
13. FATHER'S NAME <u>John T. Evans</u>		14. MOTHER'S MAIDEN NAME <u>ALICE PAQUETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>089-03-4460</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		18. INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>59</u> , to <u>Dec 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov 11</u> , 19 <u>59</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u> M.D.		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN RD</u> DATE SIGNED <u>12/5/59</u>	
PHYSICIAN'S NAME (Type) <u>DEWITT E DELAWTER MD.</u>		<u>Bethesda 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CUNNINGHAM FUNERAL HOME, INC.</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>	
ADDRESS <u>ALLEXANDRIA, VA.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

CONFIDENTIAL

MAINTAINING RECORDS OF HEALTH - BATHING 18  
13330  
CERTIFICATE OF DEATH

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13882

13840

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>1140 Bonifant St.</u>		
3. NAME OF DECEASED (Type or print) <u>Kase Washington Jenkins</u>			4. DATE OF DEATH <u>12 - 14 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-13</u>	9. AGE (In years lost birthday) <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Super. of Roads</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Kosh Jenkins</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Fincham</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes. W.W.II</u>			16. SOCIAL SECURITY NO. <u>578 10 0491</u>		
17. INFORMANT <u>Hospital Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec. 14</u> , 19 <u>59</u> , to <u>Dec. 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 14</u> , 19 <u>59</u> , and that death occurred at <u>11:15</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9241 Col. Blvd. Silver Spring, Md.</u> DATE SIGNED <u>12/14/59</u>					
ACTUAL SIGNATURE <u>J. Marion Bankhead</u> M.D.			DATE SIGNED <u>12/14/59</u>		
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>			ADDRESS <u>Silver Spring, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>			ADDRESS <u>Laytonville Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 21 59</u> DATE
24b. REGISTRAR'S SIGNATURE			DATE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 42 hours after death.

Medical Examiner - Dr. J. Marion Bankhead - called and he O.K'd my signing this certificate. JMB



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13883

13841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. Sanatorium &amp; Hospital</b>				d. STREET ADDRESS <b>7318 Carroll Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Adolph Jenkins</b> First Middle Last				4. DATE OF DEATH Month <b>Dec.</b> Day <b>19,</b> Year <b>1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/12/08 1902</b>		9. AGE (In years last birthday) <b>50 (57)</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metro-Lithograph</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert M. Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Gloria Havener</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.II Unknown</b>		17. INFORMANT <b>Mrs. Jenkins.</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Hemorrhage &amp; Laceration of left lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b>Shot Gun Wound</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted shot gun wound in left chest</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:40 o. m. 12/16/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Takoma Park Montg. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>12/19/59</b>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 22, 1959</b>		22c. NAME OF CEMETERY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO., Riverdale, Maryland.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No. 13884

13931

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>25 HRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JEFFERY BRIAN JENNINGS</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER 5 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/4/59</b>	
9. AGE (In years last birthday) <b>1</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES QUINTON JENNINGS</b>				14. MOTHER'S MAIDEN NAME <b>GRACE EVELYN SCHUSTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>HOSPITAL RECORDS OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5</b> <b>CONGENITAL ANOMALIES OF HEART</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>10</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE CONGENITAL DEFECTS</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>12/4 89</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>12/5 59</b>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>12/4 89</b> , to <b>12/5 59</b> , that I last saw the deceased alive on <b>12/5 59</b> , and that death occurred at <b>10:58 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b>							
ACTUAL SIGNATURE <b>C. H. LIGON, M. D.</b>				DATE SIGNED <b>12/5/59</b>			
PHYSICIAN'S NAME (Type) <b>C. H. LIGON, M. D.</b>				ADDRESS <b>SANDY SPRING, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Dec. 7, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc., 8454 Georgia Ave., Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

CERTIFICATE OF DEATH

1931

REPORTED BY

DECEASED

SILVER SPRING, MARYLAND

25 MAR.

AGE

321 W. 11th ST.

PORTLAND, OREGON

DECEASED

DECEASED

DECEASED

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DECEASED

GRADE 2511111111111111

JAMES HENRY HENRY

HOSPITAL RECORDS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13885

13932

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6821 Pineway 1615-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall Sanitarium</b>		d. STREET ADDRESS <b>Hyattsville Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>S.</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 23, 1866</b>
9. AGE (In years last birthday) yrs. <b>93</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Adam Sausen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Schmidt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr Rayburn H Bamberg</b>		Address <b>Hyattsville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 10, 1958</b> to <b>Dec. 9, 1959</b> , that I last saw the deceased alive on <b>Dec. 9, 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Theresa Sausen</b>		DATE SIGNED <b>5206 Norway St.</b>	
PHYSICIAN'S NAME (Type) <b>Cherry Chon, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13886

13859

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stony Creek Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u> d. STREET ADDRESS <u>Stony Creek Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Otho</u> Last <u>Johnson Jr</u>				<b>4. DATE OF DEATH</b> Month <u>Dec</u> Day <u>25</u> Year <u>1959</u>													
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-15-1913</u>		<b>9. AGE</b> (In years last birthday) <u>46</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> - - - - -		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>Wm O Johnson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillian Knott</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>WW II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>579-05-7549</u>		<b>17. INFORMANT</b> <u>Sally Johnson (wife)</u> Address <u>Stony 2</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH  									
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/></b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Port II of item 18.) <u>found on floor of closed garage</u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3:25</u> p.m. <u>12-25</u> 19 <u>59</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>		<b>20f. (City or town)</b> <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>					<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>												
<b>EXAMINER'S (Type)</b> <u>FRANK J. Broschart</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>												
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					<b>DATE SIGNED</b> <u>12-25-59</u>												
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>12-28-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Rockville, Maryland</u> (State)									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DEC 30 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John E. Hines</u>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Humphrey, Bethesda, Maryland		SEX Male	
AGE 45		RACE White	
DATE OF DEATH 12-30-59		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		SIGNATURE OF EXAMINER [Signature]	
NAME OF PHYSICIAN [Name]		NAME OF HOSPITAL [Name]	
ADDRESS OF DECEASED [Address]		CITY Bethesda	
COUNTY Montgomery		STATE Maryland	
ZIP CODE 20814		TELEPHONE [Number]	
NAME OF NEXT OF KIN [Name]		ADDRESS OF NEXT OF KIN [Address]	
CITY [City]		STATE [State]	
ZIP CODE [ZIP]		TELEPHONE [Number]	
NAME OF FUNERAL HOME [Name]		ADDRESS OF FUNERAL HOME [Address]	
CITY [City]		STATE [State]	
ZIP CODE [ZIP]		TELEPHONE [Number]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13887

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) d. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 HRS. 50 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL				d. STREET ADDRESS 11 RUSSELL AVENUE	
3. NAME OF DECEASED (Type or print) LEE		First LEE		Middle ALLNUTT	
Last JONES		4. DATE OF DEATH DECEMBER 6 19 59		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/18/92		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - MONTGOMERY CO. ROAD DEPT.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GEORGE DARBY JONES		14. MOTHER'S MAIDEN NAME EVA WILES ALLNUTT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes - War 1-Army		16. SOCIAL SECURITY NO. 220-26-1564		17. INFORMANT HOSPITAL RECORDS	
Address OLNEY, MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/7/59	
EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Monocacy	
22d. LOCATION (City, town, or county) Beallsville Md		(State) Md		24a. REC'D BY REGISTRAR DATE DEC 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna		23. FUNERAL DIRECTOR'S SIGNATURE William B. Hallen, Bancroft Md			



13934

CERTIFICATE OF DEATH

13888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ethlyn</b> Middle <b>Rita</b> Last <b>Kassel</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1906</b>
9. AGE (In years lost birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Library</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Sol Cohn</b>		14. MOTHER'S MAIDEN NAME <b>Theresa Luster</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>hepatic coma</b> <b>170 X</b> DUE TO <b>metastatic cancer of breast with metastases to lungs, bone, and liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>3 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>gastrointestinal bleeding - ? due to liver disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 8, 1959</b> , to <b>December 10, 1959</b> that I last saw the deceased alive on <b>December 10, 1959</b> , and that death occurred at <b>7:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>12-10-59</b> ACTUAL SIGNATURE <b>John L. Lewis Jr.</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>JOHN L. LEWIS JR., M. D.</b> <b>National Institutes of Health Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>DEC. 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>OXON HILL MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS</b>		24a. REC'D BY REGISTRAR <b>DEC 14 '59</b>	
ADDRESS <b>3501-14th St. N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of medical officer: [illegible]  
9. Signature of registrar: [illegible]  
10. Date: [illegible]

Intestinal obstruction - due to liver disease

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of medical officer: [illegible]  
9. Signature of registrar: [illegible]  
10. Date: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13889

13935

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3700 Adams Drive</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS WALTER KIRK</b>		4. DATE OF DEATH Month Day Year <b>December 18 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/81</b>
9. AGE (In years last birthday) yrs. <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Excavating contractor</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Excavating contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry C. Kirk</b>		14. MOTHER'S MAIDEN NAME <b>Alice E. Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Bertha A. Kirk, 3112 McComas Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Old Cerebro-Vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Two Days</b> <b>Two Weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 19 59</b> to <b>Dec 18 19 59</b> , that I last saw the deceased alive on <b>Dec 18 19 59</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>10609 Concord St. Dec 18, 1959</b>	
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D. Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE METHODIST CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, INC.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>			



# CERTIFICATE OF DEATH

File No. 100-100000

DECEASED NAME JAMES J. JONES		SEX Male		AGE 34 years	
PLACE OF BIRTH NEW YORK, N.Y.		DATE OF BIRTH 1912		PLACE OF DEATH BOSTON, MASS.	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH Natural	
DATE OF DEATH 1946		TIME OF DEATH 10:00 A.M.		PLACE OF INTERMENT BOSTON	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF NEXT OF KIN JAMES J. JONES		SIGNATURE OF PHYSICIAN JAMES J. JONES	
SIGNATURE OF REGISTRAR JAMES J. JONES		SIGNATURE OF CLERK JAMES J. JONES		SIGNATURE OF WITNESS JAMES J. JONES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13936

CERTIFICATE OF DEATH

Reg. Dist. No.

13890

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D. C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		c. LENGTH OF STAY IN 1b <b>unknown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>B.</b> Last <b>Kistler</b>		4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) <b>81 ?</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - U. S. Government</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry C. Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Julia Childs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>James B. Straughn - Laurel, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interoskeletal cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1</b> , 19 <b>59</b> , to <b>Dec. 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 29</b> , 19 <b>59</b> , and that death occurred at <b>9:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>James P. Kerr</b> M.D. <b>Thomas, Md.</b> PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation 12/2/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Et. Lincoln crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '59</b>	
ADDRESS <b>Washington, D. C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13842

## CERTIFICATE OF DEATH

Reg. Dist. No. 13891

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>8 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Jan. + Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Carl</i> First <i>Oakford</i> Middle <i>Klein</i> Last				4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-25-82</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Salesman - Cemetery</i>		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
12. CITIZEN OF WHAT COUNTRY? <i>u.s.a.</i>							
13. FATHER'S NAME <i>Charles Klein</i>				14. MOTHER'S MAIDEN NAME <i>Mary Alice Jones</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Spanish-American</i>				16. SOCIAL SECURITY NO. <i>Son-in-law</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260x</i> DUE TO <i>Cardiovascular renal disease</i> (b) <i>Diabetes mellitus</i> DUE TO <i>Coronary Thrombosis Myocardial infarction</i> (c) <i>Chronic</i> lying cause last.				INTERVAL BETWEEN ONSET AND DEATH <i>Chronic</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Summer, 1925</i> to <i>Dec. 15, 1959</i> , that I last saw the deceased alive on <i>Dec. 15, 1959</i> , and that death occurred at <i>12:15 noon</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2731 Cornwell Ave Wash D.C.</i> DATE SIGNED <i>12/15/59</i>							
ACTUAL SIGNATURE <i>Frank L. Williamson</i> M.D.							
PHYSICIAN'S NAME (Type) <i>Frank L. Williamson</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-17-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Wash D.C.</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>DEC 18 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thibault</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13843

## CERTIFICATE OF DEATH

Reg. Dist. No.

13892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		d. STREET ADDRESS <u>7809 Greenwood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Goldie</u> First <u>nmn</u> Middle <u>Knight</u> Last		4. DATE OF DEATH Month <u>13</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-94</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Brisson Hickson</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN to p's husband</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>pit chart &amp;</u>	
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>1956</u> to <u>4 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4 Dec</u> , 19 <u>59</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D. <u>8801 Colesville Road, 12/4/59</u> PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 8, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Smith</u> ADDRESS <u>254 Cawell St. N. Wash. D.C.</u>		24. REC'D BY REGISTRAR DATE <u>DEC 9 '59</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur E. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Coroner notified & approved Mr Arnold signing certificate

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

13937

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>2500 Wisconsin Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Lewis</b> Middle <b>"L"</b> Last <b>KNIGHT</b>		4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>19 59</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-7-11</b>	9. AGE (In years last birthday) <b>48 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Low L. KNIGHT</b>				14. MOTHER'S MAIDEN NAME <b>Isabella BRAZEALE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1930-1953</b>		INFORMANT <b>(Wife) Virginia B. Knight</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cor pulmonale</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emphysema, endobronchial</b> (c) <b>tuberculosis, bronchiogenic carcinoma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>6 years</b> <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>162.1</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 November, 1959</b> to <b>1 December, 1959</b> that I lost saw the deceased alive on <b>1 December, 19 59</b> and that death occurred at <b>3:59A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Vernon N Houk</b>				ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>12-1-59</b>			
PHYSICIAN'S NAME (Type) <b>V.N. HOUK LT MC USN</b>				U.S. Naval Hospital, NMMC, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hendersonville North Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Vol 2224</b>				ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12837

Director of National

Department

Washington, D.C.

2 days

Rebecca (Mrs.)

2700 Wisconsin Ave.

U.S. Naval Hospital, Bethesda Md.

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U.S. Government

U.S. Navy

Washington, D.C.

Low E. Smith

Yes 1280-1285 201-40-201 (W-12) Virginia E. Smith Same as 12

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3:25

1 December

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Washington, D.C.

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Washington, D.C.

Washington, D.C. 201-40-201 (W-12) Virginia E. Smith Same as 12

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4209 GLENROSE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMIL</b> Middle <b>W.</b> Last <b>KRYZ</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/12/92</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-28-7201</b>	
17. INFORMANT <b>Mrs. Bertha H. Kryz, 4209 Glenrose Rd. Bethesda, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unemia</b> <b>294 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Polyarteria - Vera</b> DUE TO (c) <b>Accelerated fibrillation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Accelerated fibrillation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/17/58</b> , 19___, to <b>12/8/59</b> , 19___, that I last saw the deceased alive on <b>12/8/59</b> , 19___, and that death occurred at <b>12:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>James G. O'Rourke</b> M.D.			
PHYSICIAN'S NAME (Type) <b>James A. O'Rourke MD 4501-Eden The New Look-DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WALTER E. PUMPHREY, INC. SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 11 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>(W.M.H.)</u> Last <u>Kuhn</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-00</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Natasha ? Unknown to family</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u> INFORMANT <u>Hospital Records</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>15 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Dec. 7</u> , 19 <u>59</u> that I last saw the deceased alive on <u>December 6</u> , 19 <u>59</u> , and that death occurred at <u>6:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. White</u>				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>12-7-59</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park's 12nd</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>DEC 9, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Kenna</u> ADDRESS <u>254 CARROLL ST. N.W.</u>				24. REC'D BY REGISTRAR <u>DEC 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	



My dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the purchase of land for the purpose of establishing a military reservation at the place known as the "Old Fort" in the County of ... State of ...

I have also the honor to acknowledge the receipt of your letter of the 12th inst. in relation to the same matter. In reply to inform you that the same has been forwarded to the proper authorities for their consideration. I am, Sir, very respectfully,  
Yours very truly,  
[Signature]

Very truly,  
[Signature]  
[Name]  
[Title]

13939

## CERTIFICATE OF DEATH

Reg. Dist. No.

13896

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>89 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eve</u> Middle <u>(None)</u> Last <u>Laiken</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1904</u>	
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>David Feldman</u>				14. MOTHER'S MAIDEN NAME <u>Lena Goodman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>229-44-8744</u> INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemopericardium &amp; bleeding duodenal ulcer</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cardiac decompensation</u> DUE TO (c) <u>chronic renal disease with uremia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>September 30 1959</u> , to <u>December 28, 1959</u> , that I last saw the deceased alive on <u>December 28, 1959</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laurence E. Earley</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center, Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>LAURENCE E. EARLEY, M. D.</u>				DATE SIGNED <u>December 29, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/31-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Not in New York</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 9th Ave NW</u>		24a. REC'D BY REGISTRAR <u>PC</u>	
24b. REGISTRAR'S SIGNATURE <u>C. E. Earley</u>				DATE <u>JAN 4 '60</u>		24c. REGISTRAR'S SIGNATURE <u>C. E. Earley</u>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1952

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of birth: Jan 15, 1907  
5. Place of birth: New York, U.S.A.  
6. Usual residence: 123 Main St, New York, N.Y.  
7. Date of death: Dec 10, 1952  
8. Place of death: Home  
9. Cause of death: Heart disease  
10. Nature of disease: Chronic  
11. Duration of disease: 10 years  
12. Date of onset: 1942  
13. Date of diagnosis: 1945  
14. Name of physician: Dr. J. Smith  
15. Name of hospital: St. Mary's Hospital  
16. Name of attending physician: Dr. J. Smith  
17. Name of medical examiner: Dr. J. Smith  
18. Name of coroner: Dr. J. Smith  
19. Name of registrar: Dr. J. Smith  
20. Name of undertaker: Dr. J. Smith

21. Name of informant: Dr. J. Smith  
22. Name of informant's address: 123 Main St, New York, N.Y.  
23. Name of informant's occupation: Physician  
24. Name of informant's relationship to deceased: Physician  
25. Name of informant's signature: Dr. J. Smith  
26. Name of informant's title: Physician  
27. Name of informant's institution: St. Mary's Hospital  
28. Name of informant's address: 123 Main St, New York, N.Y.  
29. Name of informant's telephone: 123-4567  
30. Name of informant's date: Dec 10, 1952

31. Name of informant's signature: Dr. J. Smith  
32. Name of informant's title: Physician  
33. Name of informant's institution: St. Mary's Hospital  
34. Name of informant's address: 123 Main St, New York, N.Y.  
35. Name of informant's telephone: 123-4567  
36. Name of informant's date: Dec 10, 1952  
37. Name of informant's signature: Dr. J. Smith  
38. Name of informant's title: Physician  
39. Name of informant's institution: St. Mary's Hospital  
40. Name of informant's address: 123 Main St, New York, N.Y.  
41. Name of informant's telephone: 123-4567  
42. Name of informant's date: Dec 10, 1952

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**13845** **CERTIFICATE OF DEATH**

13897  
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>3 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. and Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <i>411 Silver Spring Ave</i>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>Michael Joseph Lane</i>				4. DATE OF DEATH Month Day Year <i>12 13 1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>12-5-'85</i>	
9. AGE (In years lost birthday) <i>74 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <i>Retired - Govt Employee</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Postal Dept. U.S. Gov't.</i>		11. BIRTHPLACE (State or foreign country) <i>England</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>unknown Lane</i>				14. MOTHER'S MAIDEN NAME <i>unknown Shea</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>W.W.I</i>				16. SOCIAL SECURITY NO. <i>271-05-9201</i>			
17. INFORMANT <i>Hospital Records</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X Congestive Heart Failure</i> DUE TO (b) <i>Hypertensive Heart Disease</i> DUE TO (c) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Senility</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>2/16/56</i> , 19 <i>56</i> , to <i>Dec 13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Dec 13</i> , 19 <i>59</i> , and that death occurred at <i>9:15 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Philip C. Jones</i> M.D.				ADDRESS (Street, city or town, state) <i>918 Ellsworth Drive Silver Spring, Md</i>			
DATE SIGNED <i>12/13/59</i>							
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/17/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		22d. LOCATION (City, town or county) (State) <i>ARLINGTON, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC. Raymond W. Juka</i>				ADDRESS <i>SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>DEC 21 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1938

DEATH

1938

DEATH

1938

Signature of the deceased

Signature of the witness

WITNESSES

1938

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

13940

13898

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>71 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>			d. STREET ADDRESS <b>2835 29th Avenue North</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>(n)</b> Last <b>LAW</b>			4. DATE OF DEATH Month <b>December</b> Day <b>30</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-07</b>		9. AGE (In years lost birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John LAW</b>			14. MOTHER'S MAIDEN NAME <b>Fanny BRANNAN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>(Wife) Mrs. Helen A Law</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>162.1</b> IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma of Lung</b> DUE TO <b>c multiple metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>20 October</b> , 19 <b>59</b> , to <b>30 December</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>30 December</b> , 19 <b>59</b> , and that death occurred at <b>6:50 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John Walter Lewis</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>12-30-59</b>			
PHYSICIAN'S NAME (Type) <b>J.M. LEWIS LT MC USNR</b>		<b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Peacedale Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Highland Falls, New York</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi 816 "H" Street N.E. Washington, D.C.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE JAN 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1994

Name (Last, First, Middle)		Sex		Age	
John F. Kennedy		Male		35	
Date of Birth		Place of Birth		U.S. Navy	
December 20, 1929		New Orleans, Louisiana		U.S. Government	
Date of Death		Place of Death		Cause of Death	
September 22, 1963		Dallas, Texas		Assassination	
Time of Death		Manner of Death		Certificate No.	
9:57 AM		Homicide		100-100000	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Name of Physician		Name of Registrar		Name of Coroner	
F. Lee Bailey		John F. Kennedy		John F. Kennedy	
Address		Address		Address	
1000 Main Street, New York		1000 Main Street, New York		1000 Main Street, New York	
City		City		City	
New York		New York		New York	
State		State		State	
New York		New York		New York	
Country		Country		Country	
U.S.A.		U.S.A.		U.S.A.	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13899

Reg. Dist. No.

13846

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>District of Columbia</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>321 W. ST N.E. Wash DC.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Howard William Lawhorn</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>12 7 1959</u>				
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>10-1-84</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter (Retired)</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Amherst Co. Leesburg Va.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Fitz Patrick Lawhorn</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>I da Kate Grant</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>578096398</u>		<b>17. INFORMANT</b> Address <u>Mrs Catherine Lawhorn 8423 12th Ave Langley Park Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A. about 3 yrs ago</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			<b>DATE SIGNED</b> <u>12-7-59</u>				
<b>22a. BURIAL, CREMATION, or REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Dec 10, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>FT. HILL BURIAL PARK</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>LYNCHBURG, VA.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters</u>			<b>ADDRESS</b> <u>254 Carroll St. NW</u>				
<b>24a. REC'D BY REGISTRAR</b> <u>DEC 9 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Travis</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BATHING 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Print name in full)		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. OCCUPATION		8. CAUSE OF DEATH (State immediately apparent cause)		9. MANNER OF DEATH (State immediately apparent manner)		10. MEDICAL HISTORY (State immediately apparent history)		11. PRESENT ILLNESS (State immediately apparent illness)		12. POST-MORTEM EXAMINATION (State immediately apparent examination)	
13. SIGNATURE OF MEDICAL EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF JURY		16. SIGNATURE OF CORONER		17. SIGNATURE OF DEPUTY CORONER		18. SIGNATURE OF CLERK	
19. SIGNATURE OF JURY		20. SIGNATURE OF CORONER		21. SIGNATURE OF DEPUTY CORONER		22. SIGNATURE OF CLERK		23. SIGNATURE OF JURY		24. SIGNATURE OF CORONER	
25. SIGNATURE OF DEPUTY CORONER		26. SIGNATURE OF CLERK		27. SIGNATURE OF JURY		28. SIGNATURE OF CORONER		29. SIGNATURE OF DEPUTY CORONER		30. SIGNATURE OF CLERK	
31. SIGNATURE OF JURY		32. SIGNATURE OF CORONER		33. SIGNATURE OF DEPUTY CORONER		34. SIGNATURE OF CLERK		35. SIGNATURE OF JURY		36. SIGNATURE OF CORONER	
37. SIGNATURE OF DEPUTY CORONER		38. SIGNATURE OF CLERK		39. SIGNATURE OF JURY		40. SIGNATURE OF CORONER		41. SIGNATURE OF DEPUTY CORONER		42. SIGNATURE OF CLERK	
43. SIGNATURE OF JURY		44. SIGNATURE OF CORONER		45. SIGNATURE OF DEPUTY CORONER		46. SIGNATURE OF CLERK		47. SIGNATURE OF JURY		48. SIGNATURE OF CORONER	
49. SIGNATURE OF DEPUTY CORONER		50. SIGNATURE OF CLERK		51. SIGNATURE OF JURY		52. SIGNATURE OF CORONER		53. SIGNATURE OF DEPUTY CORONER		54. SIGNATURE OF CLERK	
55. SIGNATURE OF JURY		56. SIGNATURE OF CORONER		57. SIGNATURE OF DEPUTY CORONER		58. SIGNATURE OF CLERK		59. SIGNATURE OF JURY		60. SIGNATURE OF CORONER	
61. SIGNATURE OF DEPUTY CORONER		62. SIGNATURE OF CLERK		63. SIGNATURE OF JURY		64. SIGNATURE OF CORONER		65. SIGNATURE OF DEPUTY CORONER		66. SIGNATURE OF CLERK	
67. SIGNATURE OF JURY		68. SIGNATURE OF CORONER		69. SIGNATURE OF DEPUTY CORONER		70. SIGNATURE OF CLERK		71. SIGNATURE OF JURY		72. SIGNATURE OF CORONER	
73. SIGNATURE OF DEPUTY CORONER		74. SIGNATURE OF CLERK		75. SIGNATURE OF JURY		76. SIGNATURE OF CORONER		77. SIGNATURE OF DEPUTY CORONER		78. SIGNATURE OF CLERK	
79. SIGNATURE OF JURY		80. SIGNATURE OF CORONER		81. SIGNATURE OF DEPUTY CORONER		82. SIGNATURE OF CLERK		83. SIGNATURE OF JURY		84. SIGNATURE OF CORONER	
85. SIGNATURE OF DEPUTY CORONER		86. SIGNATURE OF CLERK		87. SIGNATURE OF JURY		88. SIGNATURE OF CORONER		89. SIGNATURE OF DEPUTY CORONER		90. SIGNATURE OF CLERK	
91. SIGNATURE OF JURY		92. SIGNATURE OF CORONER		93. SIGNATURE OF DEPUTY CORONER		94. SIGNATURE OF CLERK		95. SIGNATURE OF JURY		96. SIGNATURE OF CORONER	
97. SIGNATURE OF DEPUTY CORONER		98. SIGNATURE OF CLERK		99. SIGNATURE OF JURY		100. SIGNATURE OF CORONER		101. SIGNATURE OF DEPUTY CORONER		102. SIGNATURE OF CLERK	
103. SIGNATURE OF JURY		104. SIGNATURE OF CORONER		105. SIGNATURE OF DEPUTY CORONER		106. SIGNATURE OF CLERK		107. SIGNATURE OF JURY		108. SIGNATURE OF CORONER	
109. SIGNATURE OF DEPUTY CORONER		110. SIGNATURE OF CLERK		111. SIGNATURE OF JURY		112. SIGNATURE OF CORONER		113. SIGNATURE OF DEPUTY CORONER		114. SIGNATURE OF CLERK	
115. SIGNATURE OF JURY		116. SIGNATURE OF CORONER		117. SIGNATURE OF DEPUTY CORONER		118. SIGNATURE OF CLERK		119. SIGNATURE OF JURY		120. SIGNATURE OF CORONER	
121. SIGNATURE OF DEPUTY CORONER		122. SIGNATURE OF CLERK		123. SIGNATURE OF JURY		124. SIGNATURE OF CORONER		125. SIGNATURE OF DEPUTY CORONER		126. SIGNATURE OF CLERK	
127. SIGNATURE OF JURY		128. SIGNATURE OF CORONER		129. SIGNATURE OF DEPUTY CORONER		130. SIGNATURE OF CLERK		131. SIGNATURE OF JURY		132. SIGNATURE OF CORONER	
133. SIGNATURE OF DEPUTY CORONER		134. SIGNATURE OF CLERK		135. SIGNATURE OF JURY		136. SIGNATURE OF CORONER		137. SIGNATURE OF DEPUTY CORONER		138. SIGNATURE OF CLERK	
139. SIGNATURE OF JURY		140. SIGNATURE OF CORONER		141. SIGNATURE OF DEPUTY CORONER		142. SIGNATURE OF CLERK		143. SIGNATURE OF JURY		144. SIGNATURE OF CORONER	
145. SIGNATURE OF DEPUTY CORONER		146. SIGNATURE OF CLERK		147. SIGNATURE OF JURY		148. SIGNATURE OF CORONER		149. SIGNATURE OF DEPUTY CORONER		150. SIGNATURE OF CLERK	
151. SIGNATURE OF JURY		152. SIGNATURE OF CORONER		153. SIGNATURE OF DEPUTY CORONER		154. SIGNATURE OF CLERK		155. SIGNATURE OF JURY		156. SIGNATURE OF CORONER	
157. SIGNATURE OF DEPUTY CORONER		158. SIGNATURE OF CLERK		159. SIGNATURE OF JURY		160. SIGNATURE OF CORONER		161. SIGNATURE OF DEPUTY CORONER		162. SIGNATURE OF CLERK	
163. SIGNATURE OF JURY		164. SIGNATURE OF CORONER		165. SIGNATURE OF DEPUTY CORONER		166. SIGNATURE OF CLERK		167. SIGNATURE OF JURY		168. SIGNATURE OF CORONER	
169. SIGNATURE OF DEPUTY CORONER		170. SIGNATURE OF CLERK		171. SIGNATURE OF JURY		172. SIGNATURE OF CORONER		173. SIGNATURE OF DEPUTY CORONER		174. SIGNATURE OF CLERK	
175. SIGNATURE OF JURY		176. SIGNATURE OF CORONER		177. SIGNATURE OF DEPUTY CORONER		178. SIGNATURE OF CLERK		179. SIGNATURE OF JURY		180. SIGNATURE OF CORONER	
181. SIGNATURE OF DEPUTY CORONER		182. SIGNATURE OF CLERK		183. SIGNATURE OF JURY		184. SIGNATURE OF CORONER		185. SIGNATURE OF DEPUTY CORONER		186. SIGNATURE OF CLERK	
187. SIGNATURE OF JURY		188. SIGNATURE OF CORONER		189. SIGNATURE OF DEPUTY CORONER		190. SIGNATURE OF CLERK		191. SIGNATURE OF JURY		192. SIGNATURE OF CORONER	
193. SIGNATURE OF DEPUTY CORONER		194. SIGNATURE OF CLERK		195. SIGNATURE OF JURY		196. SIGNATURE OF CORONER		197. SIGNATURE OF DEPUTY CORONER		198. SIGNATURE OF CLERK	
199. SIGNATURE OF JURY		200. SIGNATURE OF CORONER		201. SIGNATURE OF DEPUTY CORONER		202. SIGNATURE OF CLERK		203. SIGNATURE OF JURY		204. SIGNATURE OF CORONER	
205. SIGNATURE OF DEPUTY CORONER		206. SIGNATURE OF CLERK		207. SIGNATURE OF JURY		208. SIGNATURE OF CORONER		209. SIGNATURE OF DEPUTY CORONER		210. SIGNATURE OF CLERK	
211. SIGNATURE OF JURY		212. SIGNATURE OF CORONER		213. SIGNATURE OF DEPUTY CORONER		214. SIGNATURE OF CLERK		215. SIGNATURE OF JURY		216. SIGNATURE OF CORONER	
217. SIGNATURE OF DEPUTY CORONER		218. SIGNATURE OF CLERK		219. SIGNATURE OF JURY		220. SIGNATURE OF CORONER		221. SIGNATURE OF DEPUTY CORONER		222. SIGNATURE OF CLERK	
223. SIGNATURE OF JURY		224. SIGNATURE OF CORONER		225. SIGNATURE OF DEPUTY CORONER		226. SIGNATURE OF CLERK		227. SIGNATURE OF JURY		228. SIGNATURE OF CORONER	
229. SIGNATURE OF DEPUTY CORONER		230. SIGNATURE OF CLERK		231. SIGNATURE OF JURY		232. SIGNATURE OF CORONER		233. SIGNATURE OF DEPUTY CORONER		234. SIGNATURE OF CLERK	
235. SIGNATURE OF JURY		236. SIGNATURE OF CORONER		237. SIGNATURE OF DEPUTY CORONER		238. SIGNATURE OF CLERK		239. SIGNATURE OF JURY		240. SIGNATURE OF CORONER	
241. SIGNATURE OF DEPUTY CORONER		242. SIGNATURE OF CLERK		243. SIGNATURE OF JURY		244. SIGNATURE OF CORONER		245. SIGNATURE OF DEPUTY CORONER		246. SIGNATURE OF CLERK	
247. SIGNATURE OF JURY		248. SIGNATURE OF CORONER		249. SIGNATURE OF DEPUTY CORONER		250. SIGNATURE OF CLERK		251. SIGNATURE OF JURY		252. SIGNATURE OF CORONER	
253. SIGNATURE OF DEPUTY CORONER		254. SIGNATURE OF CLERK		255. SIGNATURE OF JURY		256. SIGNATURE OF CORONER		257. SIGNATURE OF DEPUTY CORONER		258. SIGNATURE OF CLERK	
259. SIGNATURE OF JURY		260. SIGNATURE OF CORONER		261. SIGNATURE OF DEPUTY CORONER		262. SIGNATURE OF CLERK		263. SIGNATURE OF JURY		264. SIGNATURE OF CORONER	
265. SIGNATURE OF DEPUTY CORONER		266. SIGNATURE OF CLERK		267. SIGNATURE OF JURY		268. SIGNATURE OF CORONER		269. SIGNATURE OF DEPUTY CORONER		270. SIGNATURE OF CLERK	
271. SIGNATURE OF JURY		272. SIGNATURE OF CORONER		273. SIGNATURE OF DEPUTY CORONER		274. SIGNATURE OF CLERK		275. SIGNATURE OF JURY		276. SIGNATURE OF CORONER	
277. SIGNATURE OF DEPUTY CORONER		278. SIGNATURE OF CLERK		279. SIGNATURE OF JURY		280. SIGNATURE OF CORONER		281. SIGNATURE OF DEPUTY CORONER		282. SIGNATURE OF CLERK	
283. SIGNATURE OF JURY		284. SIGNATURE OF CORONER		285. SIGNATURE OF DEPUTY CORONER		286. SIGNATURE OF CLERK		287. SIGNATURE OF JURY		288. SIGNATURE OF CORONER	
289. SIGNATURE OF DEPUTY CORONER		290. SIGNATURE OF CLERK		291. SIGNATURE OF JURY		292. SIGNATURE OF CORONER		293. SIGNATURE OF DEPUTY CORONER		294. SIGNATURE OF CLERK	
295. SIGNATURE OF JURY		296. SIGNATURE OF CORONER		297. SIGNATURE OF DEPUTY CORONER		298. SIGNATURE OF CLERK		299. SIGNATURE OF JURY		300. SIGNATURE OF CORONER	

RECEIVED  
 DEPARTMENT OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 ALBANY, N. Y.  
 JAN 10 1918

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 DEPARTMENT OF HEALTH  
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 ALBANY, N. Y.  
 JAN 10 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13900	
Item 20 Film 253 12-23-59 ams										13941	
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5006 Hampden Lane</b>					d. STREET ADDRESS <b>5006 Hampden Lane</b>						
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>M</b> Last <b>Lehman</b>					4. DATE OF DEATH Month <b>Dec.</b> Day <b>7</b> Year <b>19 59</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 1, 1868</b>		9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>6</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Michael O'Connor</b>					14. MOTHER'S MAIDEN NAME <b>Ellen Myers</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Marie L. Kealy-daughter-same as 2d</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Crystalline Pneumonia</b> <b>904.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting Aortic Aneurysm</b> (c) <b>Generalized Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>7 Months</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Leaning over to pick up a string &amp; fell - taken to Suburban Hospital &amp; surgery performed 10 pm that nite</b>								
20c. TIME OF INJURY Month, Day, Year Hour <b>6</b> p. m. <b>May 29 19 59</b>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Her Home</b>		20f. (City or town) (County) (State) <b>Bethesda Mont. Maryland</b>				
21. I certify that I attended the deceased from <b>May 5, 1959</b> , to <b>Dec 7, 1959</b> , that I last saw the deceased alive on <b>Dec 6, 1959</b> , and that death occurred at <b>8 A M.</b> from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Leo I. Donovan</b>					ADDRESS (Street, city or town, state) <b>8016 Georgetown Rd. Bethesda Md</b>						
PHYSICIAN'S NAME (Type) <b>Leo I. Donovan, M.D.</b>					DATE SIGNED <b>12/8/59</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>12/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>					ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		

CERTIFICATE OF DEATH

1901

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>69X-3</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City (Brooklyn)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>903 Avenue S</u>			
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Allen</u> Last <u>Lorowitz</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 May 1956</u>		9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Z. Lorowitz</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Kramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro - intestinal hemorrhage</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Acute lymphocytic leukemia</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>  <u>15 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>November 17, 1959</u> to <u>December 8, 1959</u> that I last saw the deceased alive on <u>December 8, 1959</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Mengel M.D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Charles E. Mengel M.D.</u>				DATE SIGNED <u>12/8/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-9-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Goldberg Funeral Home</u>		22d. LOCATION (City, town, or county) <u>Springfield</u>		(State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				24a. REC'D BY REGISTRAR <u>DEC 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1945

STATE OF NEW YORK

County of ...

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## CERTIFICATE OF DEATH

Reg. Dist. No.

13902

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9533 East Bexhill Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>P</b> Last <b>LOWER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>3</b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Kansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Charles Potter</b>	
14. MOTHER'S MAIDEN NAME <b>Lavinia Hartley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>511-12-9186-A</b>		17. INFORMANT Address <b>Mrs. L. B. Crabbs-daughter-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerosis</b> DUE TO <b></b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>59</b> , to <b>Dec 10</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 5</b> , 19 <b>59</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Clifton R. Gruver</b> M.D. <b>4325 49th St. N.W. Wash. D.C. 12/10/59</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Clifton R. Gruver</b> <b>4325-49th St. N. W. Wash. D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>12/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, Kansas</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24. REC'D BY REGISTRAR <b>DEC 14 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13943

RECEIVED  
JAN 10 1964

13943

RECEIVED

13943

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6254 12-30-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13944

Lucas  
13903

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carrol Hall</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4903 Montgomery Lane</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington, Maryland</b>		d. STREET ADDRESS <b>Bethesda, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLE G.</b> Middle <b>Lucas</b> Last <b>Lucas</b>		4. DATE OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>2</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>3</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Kendrick</b>		14. MOTHER'S MAIDEN NAME <b>Sacks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>	
17. INFORMANT <b>William Lucas-son-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerosis generalized</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-2, 1959</b> to <b>12-18, 1959</b> , that I last saw the deceased alive on <b>12-18, 1959</b> , and that death occurred at <b>8:30 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alfred S. Norton</b>		ADDRESS (Street, city or town, state) <b>Bethesda md</b> DATE SIGNED <b>12-18-59</b>	
PHYSICIAN'S NAME (Type) <b>Alfred S. Norton</b>		<b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>12/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Jacksonville, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF D. 1911

2266



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CERTIFICATE" and "D. 1911" are visible.]*

13945

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>		c. LENGTH OF STAY IN lb <b>35 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4321 Leland Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>AGNES</b> Last <b>MAGRUDER</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>17</b> Year <b>59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/82</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES LEAMAN</b>		14. MOTHER'S MAIDEN NAME <b>EVELYN M. GLOYD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-50-2558</b>	
17. INFORMANT <b>Mr. John H. Magruder, Sr.</b>		Address <b>1024 Paul Drive, Rockville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Arteriosclerosis, general</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>5 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>OCT. 1958</b> to <b>DEC. 17, 1959</b> , that I last saw the deceased alive on <b>DEC. 17, 1959</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8218 Wisconsin Ave. Bethesda, Maryland</b> DATE SIGNED <b>12/17/59</b>			
ACTUAL SIGNATURE <b>Leo M. Curtis</b>		M.D. <b>8218 Wisconsin Ave. Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/21/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13905

13946

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>14 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Su burban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pau la</b> Middle <b>E. E</b> Last <b>Mahler</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1892</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b>	
11. IF UNDER 24 HRS. Hours <b>14</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>private pract.</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Antone Treidl</b>		14. MOTHER'S MAIDEN NAME <b>Louise Kastner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Montreal, Canada</b>		18. ADDRESS <b>Sister Louise Treidl-Kahn-8514 Cote St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>451x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Heart loss, hypotension</b> (c) <b>ruptured abdominal aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>14 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19 54</b> to <b>12-21-59</b> , that I last saw the deceased alive on <b>12-21-59</b> and that death occurred at <b>12-21-59</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John O. Robben</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7930 Georgia Ave Silver Spring Md 12-21-59</b>	
PHYSICIAN'S NAME (Type) <b>John O. Robben</b>		7930 Georgia Ave. Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/23/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

CERTIFICATE OF DEATH

13864



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## CERTIFICATE OF DEATH

Reg. Dist. No.

13906

13847

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. STREET ADDRESS <u>19808 Cokesville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel Childs McConey</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Construction Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George B. McConey</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Childs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>Mass Coronary Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May</u> , 19 <u>51</u> to <u>Dec. 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>59</u> , and that death occurred at <u>4:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u>				ADDRESS (Street, city or town, state) <u>8248 GEORGIA AVE.</u>			
DATE SIGNED <u>12/23/59</u>							
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS</u>				<u>SILVER SPRING, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Episcopal Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fina</u>			

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13008

CERTIFICATE OF DEATH

13008

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13947

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>109 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Indiana</b> b. COUNTY <b>52x-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Evansville</b> d. STREET ADDRESS <b>511 E. Franklin Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Robert Lawrence MC DANIEL</b>			4. DATE OF DEATH Month Day Year <b>December 21 1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-27</b>	9. AGE (In years lost birthday) <b>32</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Isaac MC DANIEL</b>				
14. MOTHER'S MAIDEN NAME <b>Evelyn FITZGERALD</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>				
16. SOCIAL SECURITY NO. <b>Informant Hospital Records</b>			17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>2 1/2 years</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>3 September, 1959</b> , to <b>21 December, 1959</b> , that I last saw the deceased alive on <b>21 December, 1959</b> , and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md. 12-21-59</b>							
ACTUAL SIGNATURE <b>James M. Young</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md. 12-21-59</b>					
PHYSICIAN'S NAME (Type) <b>J.M. Young LT MC USN</b>		<b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evansville Ind.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>1400 Chapin St. N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>DEC 24 1959</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



1944-1945  
OFFICE OF THE  
DIRECTOR

10

U.S. Naval Hospital, Bethesda, Md.  
U.S. Naval Hospital, Bethesda, Md.

Robert L. Davis  
Lieutenant JG DANIEL  
December 21, 1944

U.S. Marine Corps  
U.S. Government  
Lieutenant JG DANIEL  
December 21, 1944

11

U.S. Naval Hospital, Bethesda, Md.  
U.S. Naval Hospital, Bethesda, Md.  
December 21, 1944

12

## CERTIFICATE OF DEATH

Reg. Dist. No. 13908

13948

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>1005 - Crawford Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Ann</b>		First		Middle <b>Elizabeth</b>		Last <b>McHugh</b>	
4. DATE OF DEATH <b>12</b>		Month		Day <b>31</b>		Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10/7/17</b>	9. AGE (In years lost birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov.</b>		11. BIRTHPLACE (State or foreign country) <b>FLORIDA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>LOUIS A. SMITH</b>				14. MOTHER'S MAIDEN NAME <b>ESTHER HINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-09-7749</b>		INFORMANT <b>MARY LOU SAUR</b> Address <b>5521 Southwick St Bethesda MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>705.4 cerebral anoxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <b>Lupus Erythematosus</b> DUE TO (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>6 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>12/31, 1959</b> that I last saw the deceased alive on <b>12/31, 1959</b> , and that death occurred at <b>1:05 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen N. Jones</b>		M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md</b>		DATE SIGNED <b>12/31/59</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 4, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		22d. LOCATION (City, town, or county) (State) <b>WHEATON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Taltrow</b>				ADDRESS <b>3603 14th St NW</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1905

CERTIFICATE OF DEATH

1905

10-11-1905

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2212 Cobbleton Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>Bennett</u> Last <u>McKee</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C</u>	
13. FATHER'S NAME <u>William C. McKee</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Bennett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Georgeanna McKee-Item #2-Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous Coronary disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 28 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kemp</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13950

13910

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8819 Kensington Parkway</b>		d. STREET ADDRESS <b>8819 Kensington Pkwy.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>McLendon</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 9, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>13</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Robert F. Carnes</b>		14. MOTHER'S MAIDEN NAME <b>? Shaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Virginia Pendleton-daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Aneurysm of Abdominal Aorta</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Hypertensive Cardio Vascular Disease -</b> DUE TO (c) <b>Arteriosclerosis - generalized -</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b> <b>10 yr.</b> <b>20 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary insufficiency -</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan.</b> , 19 <b>57</b> , to <b>date</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 Dec.</b> , 19 <b>59</b> , and that death occurred at <b>3:15</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Ball</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7936 Old Georgetown Rd. Beth. Md.</b>	
PHYSICIAN'S NAME (Type) <b>John G. Ball</b>		<b>12/22/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bishopville Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Bishopville, S. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 28 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

13320

13320  
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON, MASSACHUSETTS  
JANUARY 1, 1912  
DECEASED  
NAME  
RESIDENCE  
AGE  
SEX  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR

1

13320  
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON, MASSACHUSETTS  
JANUARY 1, 1912  
DECEASED  
NAME  
RESIDENCE  
AGE  
SEX  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR

13320  
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON, MASSACHUSETTS  
JANUARY 1, 1912  
DECEASED  
NAME  
RESIDENCE  
AGE  
SEX  
CAUSE OF DEATH  
PLACE OF DEATH  
DATE OF DEATH  
TIME OF DEATH  
SIGNATURE OF PHYSICIAN  
SIGNATURE OF REGISTRAR

13848

## CERTIFICATE OF DEATH

Reg. Dist. No.

13911

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dr. Willard Payne McNeill</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-11-10</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Iowa Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Stanley E. McNeill</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Payne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retegenerated a Renal Undifferentiated</u> <u>198.2</u> DUE TO <u>with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infection of the Brain</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>11/24</u> , 19 <u>59</u> , to <u>12/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12/28</u> , 19 <u>59</u> , and that death occurred at <u>4:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Laurel Cove Takoma Park</u> DATE SIGNED <u>12/28/59</u> ACTUAL SIGNATURE <u>C. H. Wolohin</u> M.D. PHYSICIAN'S NAME (Type) <u>C. H. Wolohin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 2-1960</u>		<u>George Jackson Park</u>		<u>Hyattsville Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>WASH 13 D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 31 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1388

1891

*[Faint, mostly illegible handwritten text follows, likely containing details of the deceased and the circumstances of death.]*

## CERTIFICATE OF DEATH

Reg. Dist. No.

13912

13951

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>Washington</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmore Sanitarium</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>415 6th st. N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sue T. Michie</b>				4. DATE OF DEATH Month Day Year <b>Dec 29 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/12/1876</b>	
9. AGE (In years last birthday) <b>83</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Lane</b>				14. MOTHER'S MAIDEN NAME <b>Mary Twaddell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Col. J. W. Twaddell</b>			
17. INFORMANT <b>Col. J. W. Twaddell</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Streptococcal abscess</b> DUE TO <b>cardio vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>8 yrs.</b> (c) <b>8 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Washington, D.C.</b>				20g. (County) <b>Washington</b>		20h. (State) <b>D. C.</b>	
21. I certify that I attended the deceased from <b>May 1959</b> to <b>Dec 29, 1959</b> that I last saw the deceased alive on <b>Dec 29, 1959</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. H. Quayle</b>				DATE SIGNED <b>Dec 29, 1959</b>			
PHYSICIAN'S NAME (Type) <b>E. H. Quayle</b>				ADDRESS (Street, city or town, state) <b>1822 Biltmore St. N.W. Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lea Funeral Home</b>				24a. REC'D BY REGISTRAR <b>DEC 31 1959</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Adams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13952 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11919 Andrews St.</u>		d. STREET ADDRESS <u>11919 Andrews St.</u>	
3. NAME OF DECEASED (Type or print) <u>Thelma D. Miller</u>		4. DATE OF DEATH <u>Dec 8 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Harry Clark</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dated of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Suburban Hosp. record - Be Thelma md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hospitalized 1 yr ago for thrombosis left iliac vein</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-8-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blairsville</u>		22d. LOCATION (City, town, or county) (State) <u>Blairsville Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	
DATE <u>DEC 15 '59</u>			





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13914

13953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Myrtle Minnie Mitchell</u>				4. DATE OF DEATH Month Day Year <u>December 27 19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3 June 1888</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Etta Hunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-22-1892</u>			
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>141.9</u> IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u> DUE TO (b) <u>Aspiration of blood from oral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of tongue with metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 21, 1959</u> , to <u>December 27, 1959</u> , that I last saw the deceased alive on <u>December 27, 1959</u> , and that death occurred at <u>1:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/27/59</u>							
ACTUAL SIGNATURE <u>Howard S. Schwartz</u>				M.D. <u>The Clinical Center</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD S. SCHWARTZ</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12-30-59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co. Inc Wash. 10, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

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X

050

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VS A15 (4)  
15M 9/58

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13952

Department of Agriculture

Washington, D.C.

June 5, 1936

Mr. J. H. ...

Mr. J. H. ...

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13915

Reg. Dist. No.

13954

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>15360 Coleville Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MONTGOMERY COUNTY GENERAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas William Moore</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-6-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Pate Moore</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-07-4409</u>		17. INFORMANT <u>Constance Moore (wife)</u> Address <u>Slm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 11, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St, Bk</u>				24a. REC'D BY REGISTRAR <u>DEC 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

See this for

1. NAME OF DECEASED (Print or Write Full Name)  
 2. SEX  
 3. AGE  
 4. RACE  
 5. COLOR  
 6. DATE OF DEATH  
 7. PLACE OF DEATH

8. OCCUPATION  
 9. MARITAL STATUS  
 10. EDUCATION

11. CAUSE OF DEATH (Write in full)  
 12. MANNER OF DEATH (Write in full)  
 13. TIME OF DEATH (Write in full)  
 14. PLACE OF DEATH (Write in full)

15. SIGNATURE OF MEDICAL EXAMINER  
 16. SIGNATURE OF WITNESSES  
 17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY  
 19. SIGNATURE OF JUDGE  
 20. SIGNATURE OF CLERK

21. SIGNATURE OF SHERIFF  
 22. SIGNATURE OF DEPUTY SHERIFF  
 23. SIGNATURE OF CONSTABLE

24. SIGNATURE OF JURY  
 25. SIGNATURE OF JUDGE  
 26. SIGNATURE OF CLERK

27. SIGNATURE OF SHERIFF  
 28. SIGNATURE OF DEPUTY SHERIFF  
 29. SIGNATURE OF CONSTABLE

30. SIGNATURE OF JURY  
 31. SIGNATURE OF JUDGE  
 32. SIGNATURE OF CLERK

33. SIGNATURE OF SHERIFF  
 34. SIGNATURE OF DEPUTY SHERIFF  
 35. SIGNATURE OF CONSTABLE

36. SIGNATURE OF JURY  
 37. SIGNATURE OF JUDGE  
 38. SIGNATURE OF CLERK

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDEAU NURSING HOME</b>		d. STREET ADDRESS <b>8316 Carey Lane,</b>	
3. NAME OF DECEASED (Type or print) First <b>PETER</b> Middle <b>JOSEPH</b> Last <b>MORIN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgr. Meat Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Safeway Stores, Inc.</b>	
11. BIRTHPLACE (State or foreign country) <b>CANADA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>XAVIER MORIN</b>		14. MOTHER'S MAIDEN NAME <b>PHILOMENA GAUTIER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-09-2717</b>	
17. INFORMANT <b>Mrs. Regina M. Morin, 8316 Carey Lane</b>		Address <b>Silver Spring</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days several years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-26</b> , 19 <b>59</b> , to <b>12-10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12-9</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>931 Pershing Dr. Silver Spring, Md.</b> DATE SIGNED <b>12-11-59</b>			
ACTUAL SIGNATURE <b>Jason Geiger</b>		M.D. <b>931 Pershing Dr. Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>JASON GEIGER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





13956

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>65 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital NNMCM</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>48 X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Key West</b> d. STREET ADDRESS <b>Avenue E Big Coppitt Key</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Lorraine</b> Last <b>Mosier</b>			4. DATE OF DEATH Month <b>December</b> Day <b>12</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 May 1924</b>	9. AGE (In years lost birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months <b>35</b> Days <b>35</b> Hours <b>35</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Barney Belgrade</b>				
14. MOTHER'S MAIDEN NAME <b>Rose Unk.</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <b>Informant</b>			Address <b>Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.2 Carcinomatous</b> DUE TO (b) <b>Papillary Serous Cyst Adeno Carcinoma</b> DUE TO (c) <b>6 mos.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>8 October 19 59</b> to <b>12 December 19 59</b> that I last saw the deceased alive on <b>12 December 19 59</b> , and that death occurred at <b>6:00 P.</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>R.H. Perkins</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md. 12-14-59</b>					
PHYSICIAN'S NAME (Type) <b>R.H. PERKINS LT MC USN</b>		DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jewish Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Waterford Conn.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>		24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

13258

10/1/50 (10/1)

U.S. Naval Hospital

Dorothy

White

Monterey

San Francisco

No

Hospital Records

San Francisco

Monterey

May 1950

Monterey

Monterey

U.S.

12 December

10 October

12 December

R.A. FETTING JR. MD

U.S. Naval Hospital, Bethesda, Md.

Monterey County

San Francisco

12-1-50

First General Home Administration, D.C.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>8 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X KENSINGTON</b> d. STREET ADDRESS <b>3932 WASHINGTON STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM CLARENCE MOULDEN</b>		4. DATE OF DEATH Month Day Year <b>DECEMBER 29 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/77</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat cutter and Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH MOULDEN</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE BREMMIMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-01-6764</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Apoplexy, hemorrhagic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 days</b> <b>10 yrs</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/21</b> , 19 <b>55</b> , to <b>12/29</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12/29</b> , 19 <b>55</b> , and that death occurred at <b>11:22 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>A. D. Bonifant</b>		M.D. <b>SANDY SPRING, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/2/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCKVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13958

13919

1. PLACE OF DEATH a. COUNTY <b>M ontgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>M ontgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>12 Hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>E.</b> Last <b>M uldoon</b>				4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1959</b>			
5. SEX <b>M ale</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/85</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Thomas M uldoon</b>				14. MOTHER'S MAIDEN NAME <b>Kennedy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <b>Son) Burke M uldoon (same as Above)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>151X</b> DUE TO <b>Gastric Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Unknown</b> (c) <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/16</b> , 19 <b>59</b> , to <b>12/3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12/2</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Q. Elman</b> M.D.				ADDRESS (Street, city or town, state) <b>5707 Wisconsin Ave Chevy Chase, Md</b> DATE SIGNED <b>12/3/59</b>			
PHYSICIAN'S NAME (Type) <b>Donald Q. Elman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12/5/59</b>		<b>Mt. Olivet Am.</b>		<b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home</b>				ADDRESS <b>5103 Wisconsin Wash D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 7 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION



1910

CERTIFICATE OF BIRTH

1910



Blank birth certificate form with faint horizontal lines and vertical columns for data entry.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13849  
CERTIFICATE OF DEATH

Reg. Dist. No.

13920

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitorium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Thomas James Murphy, SR</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/83</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Patrick C. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gilchen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS Gertrude Silver Spring, Md.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Acute Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>5 yrs.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 1959, to <u>Dec 29</u> , 1959, that I last saw the deceased alive on <u>Dec 29</u> , 1959, and that death occurred at <u>11:20</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Wardrop MD</u>		ADDRESS (Street, city or town, state) <u>800 Pershing Drive</u> DATE SIGNED <u>12/29/59</u>	
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u> DATE <u>JAN 4 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

13848

CERTIFICATE OF DEATH

13848

1. Name of deceased: *John A. Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15, 1910*

5. Place of death: *Home*

6. Cause of death: *Heart disease*

7. Signature of physician: *Dr. J. B. Brown*

8. Signature of registrar: *Wm. H. Jones*

9. Date of registration: *Jan 20, 1910*

10. Place of registration: *Town of Springfield*

13959

## CERTIFICATE OF DEATH

Reg. Dist. No.

13921

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FAIRLAND</b>		c. LENGTH OF STAY IN 1b <b>1 yr &amp; 9 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>EMMA</b> Last <b>MUSGROVE</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/1/75</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Briggs</b>		14. MOTHER'S MAIDEN NAME <b>Frances Beckwith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Taylor O. Timberlake, Jr.</b>		Address <b>Briggs Chaney Rd., Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X Apoplexy, thrombotic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct</b> , 19 <b>25</b> , to <b>Nov Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 28</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md</b> DATE SIGNED <b>12/1/59</b>			
ACTUAL SIGNATURE <b>A. D. Bonifant</b>		M.D. <b>Sandy Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>A. D. Bonifant</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE UNION CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0321

• 1922

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

13922

Reg. Dist. No.

13960

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>33 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>5601 Greentree Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>G.</b> Last <b>Myers</b>				4. DATE OF DEATH Month <b>12</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/84</b>		9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Chief of Audits</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Myers</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Hammond</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wife - Dolly T. Myers - same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fat embolism of lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of left femur</b> (a), stating the underlying cause last. DUE TO (c) <b>903.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fe</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor at home</b>					
20c. TIME OF INJURY Month, Day, Year <b>12/18 19 59</b> Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) <b>Bethesda</b>	(County) <b>Montg.</b>	(State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>12/21/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>DEC 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MAINT AND STATE DEPARTMENT OF HEALTH - KANSAS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF DECEASED _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	
COUNTY _____		STATE _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

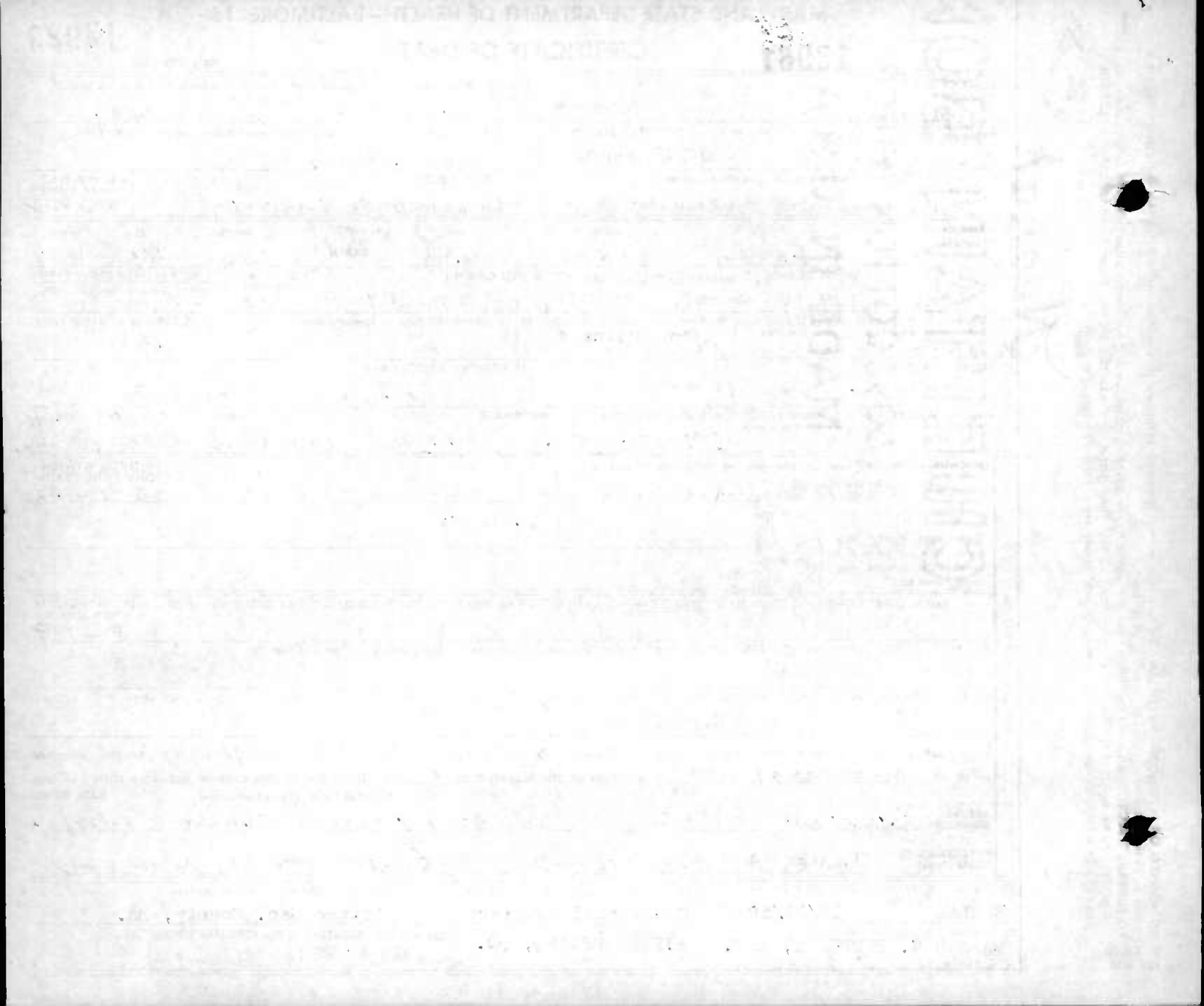
13961

CERTIFICATE OF DEATH

Reg. Dist. No.

13923

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>25 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1018 WOODSIDE PARKWAY</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>EDGAR</u> Last <u>NAU</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 25, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBING AND HEATING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE H. NAU</u>		14. MOTHER'S MAIDEN NAME <u>EMMA K. STOFFER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-07-9858</u>	
17. INFORMANT <u>AMES, MARIE E.</u>		Address <u>SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA COLON WITH LIVER</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTASIS</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>FEB. 16</u> , 19 <u>58</u> , to <u>DEC. 29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>DECEMBER 29</u> , 19 <u>59</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8207 GEORGIA AVENUE</u> <u>12/29/59</u> PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u> <u>SILVER SPRING, MARYLAND.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Zucka.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			



13962

## CERTIFICATE OF DEATH

13924

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital NNMCM</b>				d. STREET ADDRESS <b>5605 19th ST North</b>			
3. NAME OF DECEASED (Type or print) First <b>Judith</b> Middle <b>Ann</b> Last <b>Nasipak</b>				4. DATE OF DEATH Month <b>December</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 August 1955</b>	
9. AGE (In years lost birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>13</b> Hours <b>15</b> Min.		IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Valentin Nasipak</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Oliver</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
17. ADDRESS <b>(Father) Valentin Nasipak Same as #2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>180X</b> IMMEDIATE CAUSE (a) <b>Wilms' Tumor, recurrent with metastases</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>13 December, 1959</b> , to <b>13 December, 1959</b> , that I last saw the deceased alive on <b>13 December, 1959</b> , and that death occurred at <b>0840A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>12-14-59</b> ACTUAL SIGNATURE <b>H.L. Walton</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>H.L. Walton LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-17-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Elyria, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> <b>FUNERAL HOME BETHESDA, MD.</b>				24a. REC'D BY REGISTRAR <b>DEC 16 '59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13362

CENTRAL OFFICE

Form 1 (Rev. 1-1-50)

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

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U.S. Naval Hospital

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U.S. Naval Hospital

U.S. Naval Hospital

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13925									
13963										CERTIFICATE OF DEATH									
Reg. Dist. No.																			
1. PLACE OF DEATH a. COUNTY Montgomery Co					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY 10. C ✓									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47X-3									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Althea Woodland Nursing Home					d. STREET ADDRESS 2201 Weaver St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last CeCelia Nelowich					4. DATE OF DEATH Month Day Year December 27, 1959 19														
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-17-1887		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Russia					12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME Julius Zeckerman					14. MOTHER'S MAIDEN NAME Lena Zeckerman Light														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. INFORMANT Mrs. Gertrude Mensh					Address 2022 Klinge Rd., N.W.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cerebro-vascular thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular dis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 18 mo 16 years									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from April, 1952, to Dec. 27, 1959, that I last saw the deceased alive on Dec. 24, 1959, and that death occurred at 12:20 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Armand B. Gordon, M.D. 2828 Conn. Ave., N.W. Wash. D.C.																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 12-29-59					22c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery					22d. LOCATION (City, town, or county) (State) Washington, D.C.				
23. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons 3501 14th St., N.W.										24a. REC'D BY REGISTRAR DATE DEC 30 '59					24b. REGISTRAR'S SIGNATURE Arthur S. Frank				



CERTIFICATE OF DEATH

1955

STATE OF MONTANA - DEPARTMENT OF HEALTH - BAYLOR

1955



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13926

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Judith</u> First <u>Vangrall</u> Middle <u>Nelson</u> Last		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11 1940</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>alf Z. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Mary Vogt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u> Address <u>alf Z Nelson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>825X</u> DUE TO <u>EXSANGUINATION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Laceration * Rupture, Thoracic Aorta</u> DUE TO <u>Automobile Accident</u> (c) <u>Fractures of RT Femur &amp; Pelvis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Wanderer in car involved in auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-19 1959</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Mont</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brosnan</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosnan</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-20-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Md.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons</u> ADDRESS <u>Washington, DC</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
13965									
CERTIFICATE OF DEATH									
Reg. Dist. No. 13927									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville-Rural</b>			c. LENGTH OF STAY IN 1b <b>2 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville-Rural</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Matthews Nursing Home</b>					d. STREET ADDRESS <b>/</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Winston</b> Last <b>Newson</b> <b>Mary Winston</b>					4. DATE OF DEATH Month <b>December</b> Day <b>5</b> Year <b>1959</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 7-1869</b>		9. AGE (In years last birthday) <b>90</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Dr Thomas Winston</b>					14. MOTHER'S MAIDEN NAME <b>Caroline Mumford</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs Hugh Beshers, Poolesville, Md</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatous generalized</b> DUE TO (c) <b>carcinoma left breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>advance arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 months</b> <b>5 months</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <b>May</b> , 19 <b>55</b> , to <b>Dec 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 4</b> , 19 <b>59</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John G. Fawcett</b> M.D. <b>Dawsonville</b> PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT</b> <b>P.O. Bayad, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/6/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lee Funeral Home</b>			22d. LOCATION (City, town, or county) (State) <b>Wash. D. C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton, Barnesville, Maryland</b>					24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>		

1931

CERTIFICATE OF DEATH

1931

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 13966 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13928**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> c. LENGTH OF STAY IN lb <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brookville Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> d. STREET ADDRESS <u>1 Brookville Rd</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Margaret Sarah Nicholson</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec 19 1959</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-20-1890</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>md.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>	
<b>13. FATHER'S NAME</b> <u>Samuel A. Gower</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Ayres</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Edward Nicholson - Denwood B-1 md</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>12-19-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Dec. 22 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Laytonsville</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Laytonsville Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Woyw Barber</u>				<b>ADDRESS</b> <u>Laytonsville, Md</u>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
X  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13850

## CERTIFICATE OF DEATH

Reg. Dist. No.

13929

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Va</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tokoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Arlington 83x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedar Haven Rest Home</i>		d. STREET ADDRESS <i>435 North Park Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>E</i> Last <i>Partello</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 23, 1873</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Frederick Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Wiles</i>		14. MOTHER'S MAIDEN NAME <i>Anne Wiles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William C Jarvis</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage of bowel</i> <i>153.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of bowel</i> DUE TO (c) <i>with metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 11, 1959</i> to <i>Dec 30, 1959</i> , that I last saw the deceased alive on <i>Dec 30, 1959</i> , and that death occurred at <i>10:18 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Philip C Jones</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Philip E. Jones</i>		<i>Silver Spring, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>1-4-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Swirland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Wash. D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 4 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hume</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1. ~~X~~  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13860  
13930  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b <b>26</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>107 Aberdeen Rd.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b> d. STREET ADDRESS <b>107 Aberdeen Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OLIVER H. PERRY</b> First Middle Last 4. DATE OF DEATH <b>December 23, 1959</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>9/28/192</b> 9. AGE (In years last birthday) <b>67</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Dealer</b> 11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Ulyssus G. Perry</b> 14. MOTHER'S MAIDEN NAME <b>Clara D. Dean</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> 16. SOCIAL SECURITY NO. <b>WW 1</b> INFORMANT <b>Dorothy M. Perry-Item# 2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hours</b> <b>15 years</b> <b>20 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Oct 1945</b> to <b>12/23/59</b> , that I last saw the deceased alive on <b>12/23/59</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>12/24/59</b> ACTUAL SIGNATURE <b>Wm. S. Murphy</b> M.D. PHYSICIAN'S NAME (Type) <b>Wm. S. Murphy - W. Montg. Ave., Rockville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>12/26/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b> 22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home</b> ADDRESS <b>1331 E. Montgomery Avenue, Rockville, Md.</b> 24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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13967

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>57 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Clarence</b> Last <b>PIERCE</b>		4. DATE OF DEATH Month <b>December</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-14</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>2</b>	IF UNDER 24 HRS. Hours <b>2</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Albert PIERCE</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah CHAVES</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>(Wife) Dorothy M. Pierce Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Retroperitoneal Liposcarcoma addomen</b> <b>197.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>12</b> Day <b>19</b> Year <b>19 59</b> Hour <b>a. m.</b> p. m. <b>p. m.</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>23 October</b> , 19 <b>59</b> , to <b>19 December</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>19 December</b> , 19 <b>59</b> , and that death occurred at <b>7:19P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>12-21-59</b>			
ACTUAL SIGNATURE <b>Larry J. Hines</b> M.D.		PHYSICIAN'S NAME (Type) <b>L.J. HINES LCDR MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-23-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's</b> ADDRESS <b>4739 Baltimore Ave. Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 24 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>



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13968

## CERTIFICATE OF DEATH

Reg. Dist. No.

13932

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <u>Kensington Gardens Rest Home</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>				d. STREET ADDRESS <u>5236-44th., St., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>I.</u> Last <u>PUGH</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1890</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abner P. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Stanley S. Pugh</u>		Address <u>5236-44th., St., N.W.</u> <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Deside Generalized Arteriosclerosis</u> DUE TO (c) <u>Cerebral Sclerosis arteriolar</u>							INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal Tumor - Liver Enlargement</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>March, 1959</u> , to <u>12-12</u> , 1959, that I last saw the deceased alive on <u>12-12</u> , 1959, and that death occurred at <u>1:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.P. Andrews M.D.</u>				ADDRESS (Street, city or town, state) <u>4201 Fessenden St. N.W.</u>			
DATE SIGNED <u>12-12-59</u>							
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS</u>				<u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Pike, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				ADDRESS <u>5703 Wisconsin Ave. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 15 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 1001-10-60

1. NAME OF DECEASED [Handwritten: John Doe]		2. SEX [Handwritten: Male]		3. AGE [Handwritten: 45]		4. RACE [Handwritten: White]		5. DATE OF BIRTH [Handwritten: 10/15/1915]		6. PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
7. STREET ADDRESS [Handwritten: 123 Main St.]		8. CITY [Handwritten: Baltimore]		9. STATE [Handwritten: Md.]		10. ZIP CODE [Handwritten: 21201]		11. MARITAL STATUS [Handwritten: Married]		12. OCCUPATION [Handwritten: Teacher]	
13. DATE OF DEATH [Handwritten: 11/1/68]		14. TIME OF DEATH [Handwritten: 10:00 AM]		15. PLACE OF DEATH [Handwritten: Home]		16. CAUSE OF DEATH [Handwritten: Heart Disease]		17. MANNER OF DEATH [Handwritten: Natural]		18. SIGNATURE OF DECEASED [Handwritten: John Doe]	
19. SIGNATURE OF WITNESS [Handwritten: Jane Doe]		20. SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		21. SIGNATURE OF CORONER [Handwritten: Coroner]		22. SIGNATURE OF JUDGE [Handwritten: Judge]		23. SIGNATURE OF CLERK [Handwritten: Clerk]		24. SIGNATURE OF NOTARY [Handwritten: Notary]	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

2. The cause of death should be stated in as much detail as possible, and should include the immediate, intermediate, and remote causes, as far as they are known.

3. The manner of death should be stated as either natural, accidental, homicidal, suicidal, or undetermined.

4. This certificate is to be used for the purpose of determining the cause and manner of death, and for the purpose of determining the age, sex, race, and date of birth of the deceased.

5. The signature of the physician or coroner is required on this certificate.

6. The signature of the coroner is required on this certificate.

7. The signature of the judge is required on this certificate.

8. The signature of the clerk is required on this certificate.

9. The signature of the notary is required on this certificate.

10. The signature of the deceased is required on this certificate.

13969

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>205 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Reading</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75 x -3</b> d. STREET ADDRESS <b>501 Funston Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kenneth Robert Resch, Jr.</b>				4. DATE OF DEATH Month Day Year <b>December 30 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 1, 1954</b>	
9. AGE (In years lost birthday) <b>5 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Kenneth R. Resch, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Doris M. Kolewrocki</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Gastrointestinal Hemorrhage, Acute</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Leukemia</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 8</b> , 19 <b>59</b> , to <b>December 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>December 30</b> , 19 <b>59</b> , and that death occurred at <b>10:00 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b> M.D. <b>The Clinical Center</b> <b>12-30-59</b> PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/31/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lulenbach Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reading, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Korman</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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The Clinical Center, Bethesda, Md., is thanked for its assistance.

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The Medical Record

The Clinical Center, Bethesda, Maryland

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## CERTIFICATE OF DEATH

Reg. Dist. No.

13934

13970

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>4811 4th Street, Northwest</u> b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 McComas Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>H</u> Last <u>Robins</u>		4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>25</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Eichwald</u>		14. MOTHER'S MAIDEN NAME <u>Celia Feirstein</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Morris Robins (Husband)</u>		Address <u>4811 4th St. N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED METASTATIC CARCINOMA 8-9 mos</u> DUE TO (c) <u>CARCINOMA OF LEFT BREAST</u> 2YRS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 10, 1957</u> , to <u>12/10, 1959</u> that I last saw the deceased alive on <u>12/8, 1959</u> , and that death occurred at <u>4:54 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY BLVD WYATTSVILLE MD</u> DATE SIGNED <u>1/10/59</u>			
ACTUAL SIGNATURE <u>HAROLD STERLING-M.D.</u>		M.D. <u>WYATTSVILLE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 13, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		22d. LOCATION (City, town, or county) (State) <u>NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dougherty &amp; Sons</u>		ADDRESS <u>3501 14th St. NW WASH. D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>DEC 14 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13851

CERTIFICATE OF DEATH

Reg. Dist. No.

13935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>Beechhaven Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Aquila</u> Middle <u>Turner</u> Last <u>Robinson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-86</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Aquila T. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Sally P. Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>170</u>		INFORMANT <u>Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>540.0 Peptic Ulcer - hemorrhaging</u> DUE TO (b) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 6</u> , 19 <u>59</u> , to <u>Dec 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>59</u> , and that death occurred at <u>12:04</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		M.D. <u>Takoma Park, Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>12/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf Md</u>				24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kenna</u>	

1945

CERTIFICATE OF DEATH

13281

1

1

*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Place of Birth, and Cause of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]*



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1397 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13936

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10419 Mannakee St</u>				d. STREET ADDRESS <u>10419 Mannakee</u>			
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Barry</u> Last <u>Roche</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1882</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dictation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael Barry</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Buckley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Jas. A. Roche</u>		Address <u>Stu 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. M. Hanlon</u>				ADDRESS <u>- 3831-GA. Ave NW</u>		24a. REC'D BY REGISTRAR <u>DEC 18 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13972

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Parkersville</u>		c. LENGTH OF STAY IN 1b <u>18 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT GARFIELD ROLFE</u>		4. DATE OF DEATH <u>December 4 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 28, 1905</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>same</u>	11. BIRTHPLACE (State or foreign country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY GEORGE ROLFE</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET BALDWIN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1905</u>	
16. SOCIAL SECURITY NO. <u>578 05 8934</u>		17. INFORMANT <u>Marguerite R. Boggett, Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st 2nd + 3rd degree heart block</u> DUE TO (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>20 Feb. 1956</u> to <u>Dec 4 1959</u> , that I last saw the deceased alive on <u>December 2, 1959</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>John G. Fawcett</u> M.D. <u>Dawsonville</u>		PHYSICIAN'S NAME (Type) <u>JOHN G. FAWCETT MD, P.O. Box D, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/4</u>	22b. DATE THEREOF <u>12/4</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Chrysom Cemetery</u>	22d. LOCATION (City, town, or county) <u>Richmond, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Bliley, Jr.</u> ADDRESS <u>Richmond Va.</u>		24a. REC'D BY REGISTRAR <u>DATE 12/4/59</u>	24b. REGISTRAR'S SIGNATURE <u>William J. Fawcett MD</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 7 '59

Arthur S. Fawcett



CERTIFICATE OF DEATH

1937

County of \_\_\_\_\_  
City of \_\_\_\_\_  
State of \_\_\_\_\_  
No. \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Decedent's Name \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Occupation \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Signature of Physician \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_  
Date of Registration \_\_\_\_\_

13973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>X Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4025 Jones Bridge Rd.</b>				d. STREET ADDRESS <b>4025 Jones Bridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BLANCHE S. ROUNDS</b>				4. DATE OF DEATH Month Day Year <b>DEC. 18, 1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 14, 1874</b>		9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>0 4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Richford, Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank C. Sears</b>				14. MOTHER'S MAIDEN NAME <b>Addie Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. Henry Bloom-daughter- same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Generalized arterio sclerosis and</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Congestive heart failure</b> (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH <b>seventeen years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchial asthma</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1948</b> 19 to <b>Dec 18</b> 1959, that I last saw the deceased alive on <b>Dec 18</b> 1959, and that death occurred at <b>6:30 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9000 17th Street, N. W.</b> DATE SIGNED ACTUAL SIGNATURE <b>Saul Holtzman</b> M.D. PHYSICIAN'S NAME (Type) <b>Saul Holtzman</b> <b>Washington, D. C.</b> <b>12-19-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF ANALYSIS

13973

Form with multiple sections for analysis results, including fields for sample name, date, and various test results. The text is mostly illegible due to blurriness.

Sample Name: \_\_\_\_\_

Date: \_\_\_\_\_

Test Results: \_\_\_\_\_

Signature: \_\_\_\_\_

13-1-34

13852

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C. 47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>714 Albany Ave. Oak Haven Nursing Home</b>				d. STREET ADDRESS <b>2700 Connecticut Ave., N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>CYRIL</b> Middle <b>Lawrence</b> Last <b>RYALS</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-23-1886</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer- G.P.O.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Composition</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Lawrence Ryals</b>				14. MOTHER'S MAIDEN NAME <b>Judith Maria Lennan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes.</b>		16. SOCIAL SECURITY NO. <b>1918-1919</b>		INFORMANT <b>Mrs. Cecilia Ryals (Sister)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332x</b> DUE TO <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent Diabetic Mellitus (one blood sugar showing)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> , to <b>Dec 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 11, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas H Wolcott</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>7401 Blair Road NW Washington D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Chas H Wolcott</b>				Washington D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-21-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cemetery, Arlington, Va.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons, Inc. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>DEC 21 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Adams</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE VANDERBILT UNIVERSITY LIBRARY - BIRMINGHAM 15

CERTIFICATE OF DEATH

1922



13974

## CERTIFICATE OF DEATH

13940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>76 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Newport News</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83x-3</b> d. STREET ADDRESS <b>502 Hickory Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William (None) Sacker</b>				4. DATE OF DEATH Month Day Year <b>December 6 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1898</b>	
9. AGE (In years lost birthday) <b>61 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchandise Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>		11. BIRTHPLACE (State or foreign country) <b>Austria</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Max Sacker</b>				14. MOTHER'S MAIDEN NAME <b>Anna Kleinhouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>223-09-3569</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Leukemia</b> DUE TO (c) <b>Reticulum Cell Sarcoma</b>						INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 21, 1959</b> , to <b>December 6, 1959</b> , that I last saw the deceased alive on <b>December 6, 1959</b> , and that death occurred at <b>5:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>12-6-59</b> ACTUAL SIGNATURE <b>Arthur R. Rothman</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>ARTHUR R. ROTHMAN, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>--</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danyanovsky &amp; Sons</b> ADDRESS <b>3501-14th St NW</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4602 Chase Avenue</b>		d. STREET ADDRESS <b>4602 Chase Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>EDWIN</b> Middle <b>JOHN</b> Last <b>SACKETT</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>7</b>	11. IF UNDER 24 HRS. Hours <b>7</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chief</b>	
11. BIRTHPLACE (State or foreign country) <b>New York City, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Maurice Sackett</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Beaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes-Unknown</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead on bedroom floor</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED <b>12/5/59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-9-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13942

13976

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>13 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8708 Colesville Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5 Silver Spring</u> d. STREET ADDRESS <u>8708 Colesville Rd Apt 203</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Simon Sandler</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>Dec 21 1957</u> Month Day Year				
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Apr. 16 1908</u>	<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Architect Eng.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dept. of Army</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>			
<b>13. FATHER'S NAME</b> <u>Ben Sandler</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Lannie Rosnick</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Rose Ruth Sandler</u> Address <u>Itin 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broseant</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSEANT</u>			<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>12/22/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Gracie Emanuel</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John J. ...</u>			<b>ADDRESS</b> <u>1124-26 W. North Ave.</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles S. ...</u>		
<b>24c. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 23 '59</u>			<b>24d. REGISTRAR'S SIGNATURE</b> <u>Charles S. ...</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND - DEPARTMENT OF HEALTH - BALTIMORE 19  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF DEATH 10/15/1918	
5. PLACE OF DEATH Home		6. STREET ADDRESS 1234 N. E. Street		7. CITY Baltimore		8. COUNTY Baltimore	
9. OCCUPATION Carpenter		10. CAUSE OF DEATH Pneumonia		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. Harris	
13. SIGNATURE OF NEXT OF KIN J. H. Harris		14. SIGNATURE OF WITNESS J. H. Harris		15. SIGNATURE OF WITNESS J. H. Harris		16. SIGNATURE OF WITNESS J. H. Harris	
17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris		19. SIGNATURE OF WITNESS J. H. Harris		20. SIGNATURE OF WITNESS J. H. Harris	
21. SIGNATURE OF WITNESS J. H. Harris		22. SIGNATURE OF WITNESS J. H. Harris		23. SIGNATURE OF WITNESS J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris	
25. SIGNATURE OF WITNESS J. H. Harris		26. SIGNATURE OF WITNESS J. H. Harris		27. SIGNATURE OF WITNESS J. H. Harris		28. SIGNATURE OF WITNESS J. H. Harris	
29. SIGNATURE OF WITNESS J. H. Harris		30. SIGNATURE OF WITNESS J. H. Harris		31. SIGNATURE OF WITNESS J. H. Harris		32. SIGNATURE OF WITNESS J. H. Harris	
33. SIGNATURE OF WITNESS J. H. Harris		34. SIGNATURE OF WITNESS J. H. Harris		35. SIGNATURE OF WITNESS J. H. Harris		36. SIGNATURE OF WITNESS J. H. Harris	
37. SIGNATURE OF WITNESS J. H. Harris		38. SIGNATURE OF WITNESS J. H. Harris		39. SIGNATURE OF WITNESS J. H. Harris		40. SIGNATURE OF WITNESS J. H. Harris	
41. SIGNATURE OF WITNESS J. H. Harris		42. SIGNATURE OF WITNESS J. H. Harris		43. SIGNATURE OF WITNESS J. H. Harris		44. SIGNATURE OF WITNESS J. H. Harris	
45. SIGNATURE OF WITNESS J. H. Harris		46. SIGNATURE OF WITNESS J. H. Harris		47. SIGNATURE OF WITNESS J. H. Harris		48. SIGNATURE OF WITNESS J. H. Harris	
49. SIGNATURE OF WITNESS J. H. Harris		50. SIGNATURE OF WITNESS J. H. Harris		51. SIGNATURE OF WITNESS J. H. Harris		52. SIGNATURE OF WITNESS J. H. Harris	
53. SIGNATURE OF WITNESS J. H. Harris		54. SIGNATURE OF WITNESS J. H. Harris		55. SIGNATURE OF WITNESS J. H. Harris		56. SIGNATURE OF WITNESS J. H. Harris	
57. SIGNATURE OF WITNESS J. H. Harris		58. SIGNATURE OF WITNESS J. H. Harris		59. SIGNATURE OF WITNESS J. H. Harris		60. SIGNATURE OF WITNESS J. H. Harris	
61. SIGNATURE OF WITNESS J. H. Harris		62. SIGNATURE OF WITNESS J. H. Harris		63. SIGNATURE OF WITNESS J. H. Harris		64. SIGNATURE OF WITNESS J. H. Harris	
65. SIGNATURE OF WITNESS J. H. Harris		66. SIGNATURE OF WITNESS J. H. Harris		67. SIGNATURE OF WITNESS J. H. Harris		68. SIGNATURE OF WITNESS J. H. Harris	
69. SIGNATURE OF WITNESS J. H. Harris		70. SIGNATURE OF WITNESS J. H. Harris		71. SIGNATURE OF WITNESS J. H. Harris		72. SIGNATURE OF WITNESS J. H. Harris	
73. SIGNATURE OF WITNESS J. H. Harris		74. SIGNATURE OF WITNESS J. H. Harris		75. SIGNATURE OF WITNESS J. H. Harris		76. SIGNATURE OF WITNESS J. H. Harris	
77. SIGNATURE OF WITNESS J. H. Harris		78. SIGNATURE OF WITNESS J. H. Harris		79. SIGNATURE OF WITNESS J. H. Harris		80. SIGNATURE OF WITNESS J. H. Harris	
81. SIGNATURE OF WITNESS J. H. Harris		82. SIGNATURE OF WITNESS J. H. Harris		83. SIGNATURE OF WITNESS J. H. Harris		84. SIGNATURE OF WITNESS J. H. Harris	
85. SIGNATURE OF WITNESS J. H. Harris		86. SIGNATURE OF WITNESS J. H. Harris		87. SIGNATURE OF WITNESS J. H. Harris		88. SIGNATURE OF WITNESS J. H. Harris	
89. SIGNATURE OF WITNESS J. H. Harris		90. SIGNATURE OF WITNESS J. H. Harris		91. SIGNATURE OF WITNESS J. H. Harris		92. SIGNATURE OF WITNESS J. H. Harris	
93. SIGNATURE OF WITNESS J. H. Harris		94. SIGNATURE OF WITNESS J. H. Harris		95. SIGNATURE OF WITNESS J. H. Harris		96. SIGNATURE OF WITNESS J. H. Harris	
97. SIGNATURE OF WITNESS J. H. Harris		98. SIGNATURE OF WITNESS J. H. Harris		99. SIGNATURE OF WITNESS J. H. Harris		100. SIGNATURE OF WITNESS J. H. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13977

## CERTIFICATE OF DEATH

Reg. Dist. No.

13943

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3216 Reservoir Road, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Margaret</b> First <b>(None)</b> Middle <b>Sawyer</b> Last		4. DATE OF DEATH <b>December 17 1959</b> Month <b>17</b> Day <b>1959</b> Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>December 16, 1891</b> 9. AGE (In years last birthday) <b>68</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nutritionist</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Red Cross</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Albert B. Sawyer</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Wardall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Carcinoma of the breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 14, 1959</b> , to <b>December 17, 1959</b> , that I last saw the deceased alive on <b>December 17, 1959</b> , and that death occurred at <b>5:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>12/18/59</b>							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b> PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic M.D.</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Dec. 19, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			
22d. LOCATION (City, town, or county) (State) <b>Suitland, P. G., Maryland.</b>		24a. REC'D BY REGISTRAR <b>Joseph H. Taylor's Sons, WASH. DC.</b> DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			



1995

13978

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Ridgewood Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joy</u> Middle <u>M</u> Last <u>Schmitt</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/28/1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Alfred P. Marston</u>		14. MOTHER'S MAIDEN NAME <u>Alice A. Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edwin A. Schmitt-husband-same as 2d</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma of left lung</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 year</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 26</u> , 19 <u>58</u> , to <u>December 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>December 4</u> , 19 <u>59</u> , and that death occurred at <u>11:10AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5009 Del Ray Ave., Bethesda, Md. 12/6/59</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>		5009 Del Ray Ave., Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

13945

13979

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XCHEVY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROPER NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELISE Schomacher</u>				4. DATE OF DEATH Month Day Year <u>DEC 23 1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 NOV CALIFORNIA</u>	9. AGE (In years lost birthday) <u>35</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>CALIFORNIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John SAMBS</u>				14. MOTHER'S MAIDEN NAME <u>HELENE Z</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>3</u>		17. INFORMANT Address <u>F. S. MOEKALL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. A.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> 5- DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> 19 <u>59</u> , to <u>Dec 23</u> 19 <u>59</u> , that I last saw the deceased alive on <u>Nov</u> 19 <u>59</u> , and that death occurred at <u>11 A</u> . M. from the causes and on the date stated above.							DATE SIGNED
ACTUAL SIGNATURE <u>W. H. Killax</u> M.D.				ADDRESS (Street, city or town, state) <u>Wash. D. C.</u>			
PHYSICIAN'S NAME (Type) <u>W H Killax</u>				DATE <u>23 Dec 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fees Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Jones</u> ADDRESS <u>Wash. D. C.</u>				24a. RECEIVED BY REGISTRAR DATE <u>DEC 29 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13052

1. PLACE OF DEATH a. County _____ b. City or Town _____ c. Street _____ d. Apartment or Room _____		2. NAME OF DECEASED a. Full Name _____ b. Date of Birth _____ c. Sex _____ d. Race _____	
3. DATE OF DEATH a. Date _____ b. Time _____ c. Place _____		4. CAUSE OF DEATH a. Immediate Cause _____ b. Intermediate Cause _____ c. Underlying Cause _____ d. Contributing Cause _____	
5. SEX _____ 6. RACE _____ 7. AGE _____ 8. OCCUPATION _____ 9. MARITAL STATUS _____ 10. EDUCATION _____ 11. RELIGION _____ 12. BIRTHPLACE _____ 13. DATE OF BIRTH _____ 14. PLACE OF BIRTH _____ 15. DATE OF DEATH _____ 16. TIME OF DEATH _____ 17. PLACE OF DEATH _____ 18. CAUSE OF DEATH _____ 19. INTERMEDIATE CAUSE _____ 20. UNDERLYING CAUSE _____ 21. CONTRIBUTING CAUSE _____ 22. SEX _____ 23. RACE _____ 24. AGE _____ 25. OCCUPATION _____ 26. MARITAL STATUS _____ 27. EDUCATION _____ 28. RELIGION _____ 29. BIRTHPLACE _____ 30. DATE OF BIRTH _____ 31. PLACE OF BIRTH _____ 32. DATE OF DEATH _____ 33. TIME OF DEATH _____ 34. PLACE OF DEATH _____ 35. CAUSE OF DEATH _____ 36. INTERMEDIATE CAUSE _____ 37. UNDERLYING CAUSE _____ 38. CONTRIBUTING CAUSE _____		3. DATE OF DEATH a. Date _____ b. Time _____ c. Place _____	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A LICENSED NURSE. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND. IT IS NOT VALID IF SIGNED BY A PHYSICIAN OR A LICENSED NURSE WHO IS NOT CURRENTLY LICENSED IN THE STATE OF MARYLAND.



may be required by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13946
13980										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SANDY SPRING</b>					c. LENGTH OF STAY IN 1b <b>8 hrs.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 ROCKVILLE</b>					
d. STREET ADDRESS <b>4105 BEVERLY ROAD</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>EUGENE</b> Middle <b>WILEY</b> Last <b>SCOTT</b>					4. DATE OF DEATH Month <b>DEC.</b> Day <b>4</b> Year <b>1959</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/17/86</b>		9. AGE (In years last birthday) <b>73</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Entomologist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agriculture U. S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>LEVY M. SCOTT</b>					14. MOTHER'S MAIDEN NAME <b>AMANDA EDMONDSON</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES WW #1</b>					16. SOCIAL SECURITY NO. <b>none</b>					
17. INFORMANT <b>Mrs. Betsy H. Scott, 4105 Beverly Rd. Rockville, Md.</b>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Apoplexy Thrombotic</b> DUE TO <b>Diabetic mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>12 yrs</b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>8 hr</b> <b>5 yr</b> <b>12 yr</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Sept</b> , 19 <b>59</b> , to <b>Dec</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 4</b> , 19 <b>59</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md 12/4/59</b> DATE SIGNED										
ACTUAL SIGNATURE <b>A. D. Bonifant</b>					M.D. <b>Sandy Spring, Md 12/4/59</b>					
PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCKVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. POMPHREY, INC. Raymond A. Zurka</b>					ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



CERTIFICATE OF DEATH

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DEPARTMENT OF HEALTH

JULY 1914

NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13947

13853

CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		d. STREET ADDRESS <i>2444 Georgia Ave., N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <i>Frances</i> Middle <i>Lucine</i> Last <i>Schlesinger</i>		<b>4. DATE OF DEATH</b> Month <i>12</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-5-07</i>
9. AGE (In years last birthday) <i>52</i> yrs.		IF UNDER 1 YEAR Months <i>52</i> Days <i>3</i> Hours <i>47</i> Min. <i>3</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saleslady</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W. Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bell Ferrin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>577-05-961</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic Carcinoma</i> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Cervix</i> DUE TO (c) <i>about 12 months</i> about 1 year		INTERVAL BETWEEN ONSET AND DEATH <i>about 12 months</i> <i>about 1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>June 10, 1954</i> to <i>December 2, 1959</i> , that I last saw the deceased alive on <i>December 1, 1959</i> and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Benjamin Isaacson</i>		ADDRESS (Street, city or town, state) <i>M.D. 7733 Alaska Ave. 3rd Fl. Wash D.C. 12/2/59</i>	
PHYSICIAN'S NAME (Type) <i>Benjamin Isaacson</i>		DATE SIGNED <i>DEC 3 '59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>12/4/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery Washington, D.C.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. McQuay</i>		24a. REC'D BY REGISTRAR <i>DEC 3 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

CERTIFICATE OF DEATH

1922

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13948

13981

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>85 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>3224 Martha Curtis Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward (No middle name) Siff</b>		4. DATE OF DEATH Month Day Year <b>December 18 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4 January 1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mgt. Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon L. Siff</b>		14. MOTHER'S MAIDEN NAME <b>Lena Levin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia and Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Perforation of Stomach</b> DUE TO (c) <b>Malignant Lymphoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b> <b>3 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 24, 19 59</b> , to <b>December 18, 19 59</b> , that I last saw the deceased alive on <b>December 18, 19 59</b> , and that death occurred at <b>7:40 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>12/18/59</b> ACTUAL SIGNATURE <b>Norman R. Gevirtz</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>NORMAN R. GEVIRTZ, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		22d. LOCATION (City, town, or county) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc 7100 Entaw Place</b> ADDRESS <b>7100 Entaw Place</b>		24a. REC'D BY REGISTRAR <b>DEC 22 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoma</b>			

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## Abstract

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13854

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13949  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>6 hrs. 55 min</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		d. STREET ADDRESS <i>206 Indian Spring Dr.</i>	
3. NAME OF DECEASED (Type or print) <i>Samuel (None) Smackey</i>		4. DATE OF DEATH <i>12 20 - 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-1882</i>
9. AGE (In years last birthday) <i>77</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MERCHANT (Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>	
11. BIRTH PLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. 9.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Washington Sanitarium &amp; Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Contusions and lacerations</i> DUE TO (c) <i>A fall down stairs</i> INTERVAL BETWEEN ONSET AND DEATH <i>9 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Reported to have fallen down stairs at home</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>12-20-1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) <i>Silver Spring Md</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschert</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/21/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MONTIFIGRE CEM.</i>		22d. LOCATION (City, town, or county) (State) <i>SPRINGFIELD GARDENS, N.Y.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dealey Funeral Home</i>		24a. REC'D BY REGISTRAR <i>4217-9th Ave</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>DEC 23 '59</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
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FOR STATE

HEALTH DEPT.

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1- MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13861

CERTIFICATE OF DEATH

Reg. Dist. No.

13950

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 W. Argyle Street</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b> d. STREET ADDRESS <b>2 W. Argyle Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSE E. SMITH</b> First Middle Last		4. DATE OF DEATH <b>Dec. 31, 1959</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/1873</b> 9. AGE (In years lost birthday) <b>86</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Charles W. Forsyth</b>	
14. MOTHER'S MAIDEN NAME <b>Mary F. Utterback</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs Wm. V. Robertson-Item#2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>002x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>For advanced active pulmonary tuberculosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1950</b> , 19, to <b>Dec 31</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec 25</b> , 19 <b>59</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1105 S. Washington St. Rockville, Md.</b> DATE SIGNED <b>12/31/59</b> ACTUAL SIGNATURE <b>Wm. A. Linthicum</b> M.D. PHYSICIAN'S NAME (Type) <b>Wm. A. Linthicum</b> <b>Rockville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/2/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Funeral Home - Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13951

13982

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>F</b> Last <b>Smoot</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>31</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/11/95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman - Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Agriculture</b>	
13. FATHER'S NAME <b>FRANK P. SMOOT</b>		14. MOTHER'S MAIDEN NAME <b>MARY BEECHAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or range of years) <b>ARMY</b>		16. SOCIAL SECURITY NO. <b>578-18-2023</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sept 15-59 - Coronary in xantha with occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12-11-59</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-15</b> , 19 <b>59</b> , to <b>12-31</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12-31</b> , 19 <b>59</b> , and that death occurred at <b>9:40</b> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. Nolan</b> M.D.		ADDRESS (Street, city or town, state) <b>5401 Western Ave N.W.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>JAMES E. NOLAN</b>		<b>Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/5/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b> ADDRESS <b>14th Rainier</b> <b>md.</b>		24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knepp</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

First Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
Age \_\_\_\_\_  
Rank \_\_\_\_\_  
Service \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Signature \_\_\_\_\_  
Official \_\_\_\_\_  
Date \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13983

## CERTIFICATE OF DEATH

Reg. Dist. No. 13952

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>75 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Baldwin, Long Island</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>69 X-3</u> d. STREET ADDRESS <u>1832 Longfellow Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Janet</u> Middle <u>Mary</u> Last <u>Spinrad</u>		4. DATE OF DEATH Month <u>December</u> Day <u>27</u> Year <u>1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 16, 1912</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Litho-Stripper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Ralph E. Cole</u>			14. MOTHER'S MAIDEN NAME <u>Frances Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> <u>170 x</u> DUE TO <u>tracheobronchitis with mucous obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and bilateral pleural effusion</u> DUE TO (c) <u>metastatic carcinoma from the left breast</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>months</u> <u>months</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 13, 1959</u> , to <u>December 27, 1959</u> , that I last saw the deceased alive on <u>December 27, 1959</u> , and that death occurred at <u>2:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>December 28, 1959</u> ACTUAL SIGNATURE <u>Richard C. Mechanic</u> PHYSICIAN'S NAME (Type) <u>RICHARD C. MECHANIC, M. D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/28/59</u>		22b. DATE THEREOF <u>12/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Green County New York</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u> <u>7557 Wisconsin Ave Bethesda, Md</u>			24c. REC'D BY REGISTRAR DATE <u>DEC 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



CERTIFICATE OF DEATH

1908

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF NEXT OF KIN</p>	
<p>15. SIGNATURE OF CLERGYMAN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF HEALTH OFFICIAL</p>		<p>20. SIGNATURE OF COUNTY CLERK</p>	
<p>21. SIGNATURE OF CITY CLERK</p>		<p>22. SIGNATURE OF STATE CLERK</p>	
<p>23. SIGNATURE OF DEPARTMENT OF HEALTH</p>		<p>24. SIGNATURE OF U.S. DEPARTMENT OF HEALTH</p>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13953

13984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambrills,</u> <u>02X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Sterling</u>		4. DATE OF DEATH Month <u>December</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinery</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George W. Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Clara Lott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>578-09-9303</u>	
INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Pneumonitis, Right Lung, secondary to</u> <u>204.3</u> DUE TO <u>Monilia.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myelogenous Leukemia.</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 Week</u> <u>2 Months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 27, 1959</u> , to <u>December 31, 1959</u> , that I last saw the deceased alive on <u>December 31, 1959</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>1/1/60</u>			
ACTUAL SIGNATURE <u>Harold J. Fallon</u>		M.D. <u>The Clinical Center</u>	
PHYSICIAN'S NAME (Type) <u>HAROLD J. FALLON, M.D.</u>		<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

13984

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# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13954

13985

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>212 Brooks Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arnold</u> Middle <u>Raymond</u> Last <u>Stull</u>				<b>4. DATE OF DEATH</b> Month <u>12</u> Day <u>21</u> Year <u>59</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5/25/1901</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Ulysses Stull</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary J. Kaiser</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Mary Stull (wife)</u>		Address <u>Item 2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>History of previous coronary disease</u>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>  19  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brischart</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Brischart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>12-21-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Oak</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Gaithersburg, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Kraus</u>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>DEC 22 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13855  
CERTIFICATE OF DEATH

Reg. Dist. No. 13955

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>GORDON</u> Middle <u>VR</u> Last <u>SUTHARD, JR.</u>		4. DATE OF DEATH <u>DEC 31 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/59</u>
9. AGE (In years last birthday) yrs. <u>12</u>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.	11. IF UNDER 24 HRS. Hours <u>12</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Gordon Keith Suthard</u>	
14. MOTHER'S MAIDEN NAME <u>Isabelle Agnes LeTourneau</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mother's Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation - Pullid</u> 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DIFFICULT DELIVERY AT BIRTH</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 30</u> , 19 <u>59</u> , to <u>Dec 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>59</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1515 HIGHLAND DRIVE SILVER SPRING MD</u> DATE SIGNED <u>Jan 4 '60</u>			
ACTUAL SIGNATURE <u>George B. Spence</u> M.D.		DATE SIGNED <u>Jan 4 '60</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE B. SPENCE</u>		DATE SIGNED <u>Jan 4 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Zucka</u> ADDRESS <u>2075 38th X 06</u>		24a. REC'D BY REGISTRAR <u>Jan 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			



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INVESTIGATION OF

1388

RECEIVED  
MAY 11 1964  
FBI - NEW YORK

TO DIRECTOR, FBI (100-100000)  
FROM SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph letter or report.]



1 ~~X~~  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
13986  
CERTIFICATE OF DEATH

Reg. Dist. No. 13956

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Orville</u> Middle <u>Franklin</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 April 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Repairman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>// George Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Trader</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>330-05-5948</u>			
17. INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO 163x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epidermoid Carcinoma, Lung</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 23, 1959</u> , to <u>December 13, 1959</u> , that I last saw the deceased alive on <u>December 13, 1959</u> , and that death occurred at <u>10:25 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center, Bethesda 14, Maryland</u> DATE SIGNED <u>12-13-59</u>							
ACTUAL SIGNATURE <u>Charles E. Mengel, M.D.</u>							
PHYSICIAN'S NAME (Type) <u>CHARLES E. MENGEL, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>							
22b. DATE THEREOF <u>12/16/59</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>							
22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>							
24a. REC'D BY REGISTRAR <u>DEC 16 '59</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

10:28:25 AM

13856

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>14 Cleveland Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Sophia</u> Last <u>Terrill</u>		4. DATE OF DEATH Dec 11 1959	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-10-72</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Blanche L. Terrill Longland - N.Y.</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Left Hemiplegia</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from 7 Dec 1959, to 11 Dec 1959, that I last saw the deceased alive on 10 Dec 1959, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE A. B. Queen M.D. 7112 Willow Ave ADDRESS (Street, city or town, state) Takoma Park DATE SIGNED 11 Dec 1959

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>Dec-14-1959</u>	<u>St. Anne Church Cemetery</u>	<u>Blm. Green, West Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Arthur Hatten</u>	<u>254 Carroll St N.W.</u>	<u>DEC 14 '59</u>	<u>Arthur S. Hatten</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

151 - 1st of Nov. 1891

Received. 12-14-1954. The above copy of the letter to the  
Director of the FBI, dated 12-14-1954.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13987

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

13958

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>37 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>D</b> Last <b>THIEBAUD</b>				4. DATE OF DEATH Month <b>December</b> Day <b>20</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-7-57</b>	
9. AGE (In years lost birthday) <b>2</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.		IF UNDER 24 HRS. Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Charles J. THIEBAUD</b>				14. MOTHER'S MAIDEN NAME <b>Herta WARTGEG</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>(Father) Charles J. Thiebaud Same as #2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEUROBLASTOMA</b> <b>193.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>13 November, 1959</b> , to <b>20 December, 1959</b> , that I last saw the deceased alive on <b>20 December, 1959</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Fred W. Grello</b> M.D. <b>U.S. Naval Hospital, Bethesda Md. 12-21-59</b> PHYSICIAN'S NAME (Type) <b>F.W. GRELLIO LT MC USN</b> <b>U.S. Naval Hospital, Bethesda Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-24-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Hampton Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hampton Va.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Hayden Smith</b>				ADDRESS <b>245 Armistead Ave. Hampton Va.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							



13987

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U.S. Navy (Hill), Section 101

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13959

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Co. Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Malchia</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/14</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Clifton Edward Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mamie Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Hospital records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st, 2nd and 3rd degree burns involving head, trunk and extremities.</u> DUE TO (c) <u>burning of house.</u> INTERVAL BETWEEN ONSET AND DEATH <u>7½ hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burning of home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9-20</u> a. m. <u>12</u> p. m. <u>16</u> <u>19 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Sandy Spring, Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart,</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>DEC 22 '59</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13960

13989

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
f. STREET ADDRESS <u>4919 SEDGWICK ST., N.W.</u>				g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John W Thompson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/9/1892</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROSS THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>WENA DeBRULER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war on dates of service) <u>WORLD WAR I</u>				16. SOCIAL SECURITY NO. <u>577-03-1023</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, right lung.</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. anemia 2. congestive heart failure. 3. Parkinson's disease.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hours.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> , 19 <u>58</u> , to <u>4 December</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 December</u> , 19 <u>59</u> , and that death occurred at <u>10:08 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Seruch T. Kimble</u> M.D. <u>929 Plushing Drive</u> <u>4 Dec., 1959.</u>				ADDRESS (Street, city or town, state) <u>Silver Spring, Maryland</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FORT MYER, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hewitt</u> ADDRESS <u>1756 PA. AVE., N.W. DC</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

15289

Thompson

John

x

W

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13990

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital NNMC</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna 83x-3</b>			
f. STREET ADDRESS <b>RT#3 Box 490</b>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rose</b> First <b>Yearly</b> Middle <b>Yearly</b> Last <b>THOMPSON</b>				4. DATE OF DEATH <b>December 12 1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 30 82</b>	
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR <b>Months</b>		11. IF UNDER 24 HRS. <b>Days</b>		12. IF UNDER 24 HRS. <b>Hours</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Thomas Yearly</b>				14. MOTHER'S MAIDEN NAME <b>Alice CRABTREE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT (Son) Robert THOMPSON</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma Rectum &amp; metastases</b> <b>154x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>25 November, 1959</b> , to <b>12 December, 1959</b> , that I last saw the deceased alive on <b>12 December, 1959</b> , and that death occurred at <b>4:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>B. C. Johnson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>B.C. Johnson</b> <b>LCDR MC USN</b> <b>U.S. NAVAL HOSPITAL Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>12-15-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Cecil Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Vienna, Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Tyson Wheeler Funeral Home Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 16 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

2

1



11

1

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH

1. Name of Deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of Birth: *Jan 15 1900*  
5. Date of Death: *Dec 10 1945*  
6. Place of Death: *New York City*  
7. Cause of Death: *Heart Disease*  
8. Signature of Physician: *John Doe*  
9. Signature of Registrar: *John Doe*  
10. Signature of Coroner: *John Doe*

11. Signature of Medical Examiner: *John Doe*  
12. Signature of Health Officer: *John Doe*  
13. Signature of County Clerk: *John Doe*  
14. Signature of City Clerk: *John Doe*  
15. Signature of Town Clerk: *John Doe*  
16. Signature of Village Clerk: *John Doe*  
17. Signature of Ward Clerk: *John Doe*  
18. Signature of Precinct Clerk: *John Doe*  
19. Signature of Block Clerk: *John Doe*  
20. Signature of Street Clerk: *John Doe*

13991

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>2318 - 16th Street, S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick (None) Trossbach</u>				4. DATE OF DEATH Month Day Year <u>December 24 19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4 July 1890</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Trossbach</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Romeise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-14-3427</u>			
INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Arteriolar Nephrosclerosis</u> DUE TO (c) <u>Carcinoma of the Rectum</u> INTERVAL BETWEEN ONSET AND DEATH <u>73 days</u> <u>? years</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Metastatic Carcinoma in Liver, Myocardial Hypertrophy, Atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>November 13, 19 59</u> , to <u>December 24, 19 59</u> that I last saw the deceased alive on <u>December 24, 19 59</u> , and that death occurred at <u>11:05 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12/25/59</u> ACTUAL SIGNATURE <u>Alan B. Retik</u> M.D. <u>The Clinical Center</u> PHYSICIAN'S NAME (Type) <u>ALAN B. RETIK, M.D.</u> <u>National Institutes of Health Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/28/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>				22d. LOCATION (City, town, or county) (State) <u>Ridge, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 30 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Colin L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1991

CENTRAL

1

1991

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your own use. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13992

Reg. Dist. No.

13963

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>21 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9010 Seneca Lane</b>			d. STREET ADDRESS <b>9010 Seneca Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>D</b> Last <b>Urry</b>			4. DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1905</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Scientist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>					
13. FATHER'S NAME <b>Albert Urry</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Greta Urry-wife-same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John G. Ball</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John G. Ball</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Rockville, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>			24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

## 1505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13964

13993

1. PLACE OF DEATH o. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>City</b>				c. LENGTH OF STAY IN 1b <b>7Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montg, Co, General Hospital</b>				d. STREET ADDRESS <b>111 Walker Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marshall</b> Middle <b>Murray</b> Last <b>Walker</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>17</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 19-1880</b>	
9. AGE (In years lost birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>28</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retail Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Gaithersburg Md,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George E. Walker</b>				14. MOTHER'S MAIDEN NAME <b>Ella S. Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		INFORMANT <b>11 Address Walker Ave</b> <b>Minnie B. Walker. Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, Retroperitoneal, 451X</b> DUE TO <b>due to rupture abdominal aorta.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , 19 <b>Dec. 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Dec. 18</b> , 19 <b>59</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 Russell Ave. Gaithersburg, Md.</b> DATE SIGNED <b>12-18-59</b>							
ACTUAL SIGNATURE <b>Jack Schumacher</b>				PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12-19-59</b>		<b>Forest Oak</b>		<b>Gaithersburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel E. Galt</b> ADDRESS <b>Gaithersburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Frank</b>	

MEDICAL CERTIFICATION



1903

STATE OF NEW YORK

1903

IN SENATE

REPORT OF THE  
COMMISSIONER OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1902  
ALBANY: J.B. LEECH, STATE PRINTER  
1903

ALBANY: J.B. LEECH, STATE PRINTER  
1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13965

13994

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville 26</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>308 Greenlith</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EOLIA</u> Middle <u>Ann</u> Last <u>Ward</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1959</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1876</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>									
13. FATHER'S NAME <u>Huthorn</u>				14. MOTHER'S MAIDEN NAME <u>Anderson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT Address <u>Rockville Md</u> <u>Paul B. Wardell, 308 Greenlith</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombus</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>58</u> , to <u>3 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 Dec</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>W.S. Murphy</u>				ADDRESS (Street, city or town, state) <u>65 W. Montgomery Ave 3 Dec 59</u>					
PHYSICIAN'S NAME (Type) <u>W.S. MURPHY</u>				DATE SIGNED <u>Rockville Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>				ADDRESS <u>Mt. Rainier, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 7 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>									

CERTIFICATE OF DEATH

1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13995

CERTIFICATE OF DEATH

Reg. Dist. No. 215

13966

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>08X-2</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wanda Deane WARREN</b>		4. DATE OF DEATH Month Day Year <b>December 4 1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-13-16</b>		9. AGE (In years lost birthday) yrs. <b>43</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Horace Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Zell M. JOHNSON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT (Husband) James L. Warren Same as #2</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581.1</b> DUE TO <b>Intestinal obstruction + electrolyte imbalance</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lamie's cirrhosis</b> DUE TO <b>1 year</b> (c) <b>1 year</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>6 November</b> , 19 <b>59</b> , to <b>4 December</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>4 December</b> , 19 <b>59</b> , and that death occurred at <b>6:55A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md</b>		DATE SIGNED <b>12-4-59</b>			
ACTUAL SIGNATURE <b>R. G. Muth</b>		PHYSICIAN'S NAME (Type) <b>R.G. MUTH LT MC USN</b>		M.D. <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-8-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumpfrey</b>		ADDRESS <b>7351 Wisconsin Ave. Bethesda Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knease</b>			

13006  
212

EXHIBIT A, 100 0000

13006

John Island

25 days

no. 1000 (1000)

U.S. Naval Hospital, Bethesda, Md.

December

January

March

April

#3

10-13-40

10

10-13-40

10-13-40

U.S.

Indiana

10-13-40

10-13-40

Bill M. Johnson

10-13-40

(H. M. Johnson, 1000 1000)

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

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U.S. Naval Hospital, Bethesda, Md.

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

10-13-40

10-13-40

U.S. Naval Hospital, Bethesda, Md.

13996

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>King George</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>King George</u> <u>83x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>Route #2, Box 68</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>George</u> Last <u>Wegner</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 January 1897</u>
9. AGE (In years lost birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public works inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul L. Wegner</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Roesky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>UNASCERTAINABLE</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>thrombosis of thoracic and abdominal aorta</u> <u>451x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized severe arteriosclerosis</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malignant lymphoma: skin, lymph nodes, spleen, kidney, liver</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 19, 1959</u> , to <u>December 28, 1959</u> that I last saw the deceased alive on <u>December 28, 1959</u> , and that death occurred at <u>5:30 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center, Bethesda 14, Maryland</u> DATE SIGNED <u>December 28, 1959</u>			
ACTUAL SIGNATURE <u>Richard C. Mechanic</u>		M.D. <u>The Clinical Center, Bethesda 14, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD C. MECHANIC, M. D.</u>		National Institutes of Health	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>	22d. LOCATION (City, town, or county) (State) <u>Owens, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nash &amp; Slaw by [Signature]</u>		ADDRESS <u>Ninde, Virginia</u>	
24a. REC'D BY REGISTRAR <u>DEC 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. Name of patient: \_\_\_\_\_  
2. Date of admission: \_\_\_\_\_  
3. Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
4. Race: \_\_\_\_\_  
5. Marital status: \_\_\_\_\_  
6. Education: \_\_\_\_\_  
7. Occupation: \_\_\_\_\_  
8. Present address: \_\_\_\_\_  
9. Previous addresses: \_\_\_\_\_  
10. Family history: \_\_\_\_\_  
11. Social history: \_\_\_\_\_  
12. Medical history: \_\_\_\_\_  
13. Mental history: \_\_\_\_\_  
14. Physical examination: \_\_\_\_\_  
15. Laboratory tests: \_\_\_\_\_  
16. X-ray films: \_\_\_\_\_  
17. Pathological findings: \_\_\_\_\_  
18. Treatment: \_\_\_\_\_  
19. Prognosis: \_\_\_\_\_  
20. Remarks: \_\_\_\_\_

21. Signature of attending physician: \_\_\_\_\_  
22. Date: \_\_\_\_\_  
23. Signature of hospital administrator: \_\_\_\_\_  
24. Date: \_\_\_\_\_  
25. Signature of patient: \_\_\_\_\_  
26. Date: \_\_\_\_\_  
27. Signature of family member: \_\_\_\_\_  
28. Date: \_\_\_\_\_  
29. Signature of social worker: \_\_\_\_\_  
30. Date: \_\_\_\_\_  
31. Signature of nurse: \_\_\_\_\_  
32. Date: \_\_\_\_\_  
33. Signature of dietitian: \_\_\_\_\_  
34. Date: \_\_\_\_\_  
35. Signature of pharmacist: \_\_\_\_\_  
36. Date: \_\_\_\_\_  
37. Signature of other personnel: \_\_\_\_\_  
38. Date: \_\_\_\_\_  
39. Signature of patient's representative: \_\_\_\_\_  
40. Date: \_\_\_\_\_  
41. Signature of hospital representative: \_\_\_\_\_  
42. Date: \_\_\_\_\_  
43. Signature of state representative: \_\_\_\_\_  
44. Date: \_\_\_\_\_  
45. Signature of federal representative: \_\_\_\_\_  
46. Date: \_\_\_\_\_  
47. Signature of other representative: \_\_\_\_\_  
48. Date: \_\_\_\_\_  
49. Signature of patient's representative: \_\_\_\_\_  
50. Date: \_\_\_\_\_

## CERTIFICATE OF DEATH

Reg. Dist. No.

13968

13997

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7611 Whittier Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA BELLE WELLS</b>		4. DATE OF DEATH Month Day Year <b>Dec. 30, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1872</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Charles Storrin</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Robert A. Wells-son-same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, LEFT</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERAL</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 HRS.</b> <b>5 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE</b> , 19 <b>58</b> , to <b>DEC. 30, 1959</b> , that I last saw the deceased alive on <b>DEC. 30</b> , 19 <b>59</b> , and that death occurred at <b>8:15</b> p.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo M. Curtis</b>		M.D. <b>XX</b> ADDRESS (Street, city or town, state) <b>8218 Wisconsin Ave.</b> DATE SIGNED <b>12-31-59</b>	
PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS</b>		<b>Bethesda, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/2/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 4 60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haus</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1932

Montgomery  
Burial  
7th Street  
Burial

Jan 30 1932  
June 21 1932  
White

New York  
Charles  
Lionel

No  
100-100-100

1932

1932

1932

1932

1932

13998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3113 Ferndale Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pauline A Wighington</b>				4. DATE OF DEATH Month Day Year <b>Dec. 29 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1920</b>	9. AGE (In years last birthday) <b>39 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>3 4</b>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Paul V. Reardon</b>				14. MOTHER'S MAIDEN NAME <b>Minnie I. Hill</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT Address <b>same as 2d</b> <b>Victor E. Wighington, Jr.-Husband-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>1950</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HEPATIC METASTASES</b> DUE TO (c) <b>CARCINOMA, RIGHT ADRENAL GLAND</b>						INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS.</b> <b>3 MOS</b> <b>9 MOS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/11/1959</b> to <b>12/29, 1959</b> , that I last saw the deceased alive on <b>12/29/1959</b> , and that death occurred at <b>7:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John H. Tuohy</b>		M.D.		ADDRESS (Street, city or town, state) <b>7720 WISCONSIN AVE BETHESDA 14, MD.</b>		DATE SIGNED <b>12/29/59</b>	
PHYSICIAN'S NAME (Type) <b>John H. Tuohy</b>		7720 Wisc. Ave. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/4/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 4 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13999

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <b>83X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5868 South 1st Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Jerry</b> Middle <b>Lee</b> Last <b>Williams</b>				4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 28, 1940</b>		9. AGE (In years lost birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Iradell David Williams</b>				14. MOTHER'S MAIDEN NAME <b>Dolores Cornelia George</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>403-50-5513</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Subarachnoid Hemorrhage</b> DUE TO <b>204.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Pulmonary Edema</b> DUE TO <b>Acute Myelogenous Leukemia with massive enlargement of spleen, liver, lymph nodes and kidneys</b> (c) <b>9 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 6, 1959</b> to <b>December 6, 1959</b> that I last saw the deceased alive on <b>December 6, 1959</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>12/6/59</b>							
ACTUAL SIGNATURE <b>Arthur R. Rothman</b>				M.D. <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Arthur R. Rothman M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>TRASTORAL</b>		<b>12-8-59</b>		<b>MT. KENTON</b>		<b>PADUCAN KY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. [Signature]</b>				ADDRESS <b>ARLINGTON, VA</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
				24a. REC'D BY REGISTRAR DATE <b>DEC 9 '59</b>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14000

## CERTIFICATE OF DEATH

Reg. Dist. No.

13971

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> <b>D.C. COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>FRANCIS</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 21, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>11</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reg. Officer-VA Adm.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt- Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Frank Williams</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Son</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20, 1947</b> to <b>Dec 11, 1959</b> that I last saw the deceased alive on <b>Nov 28, 1959</b> , and that death occurred at <b>2:58</b> A.M. from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <b>William L. Howell</b> M.D. <b>5401 Western Ave. N.W. Wash D.C.</b> PHYSICIAN'S NAME (Type) <b>William L. HOWELL</b> <b>5401 Western Ave. N.W. 12/12/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Knapp</b>	

CERTIFICATE OF DEATH

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14001  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Mont. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. LENGTH OF STAY IN 1b <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LeDeau Gardens Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>C.</b> Last <b>WORTHINGTON</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1880</b>
9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>23</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Life Insurance salesman -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George Y. Worthington</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Taliaferro</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>579-268-348</b>	
17. INFORMANT <b>Mrs. George Dickson - Daughter</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diverticulitis, Colon</b> DUE TO (c) <b>Diverticulosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 19</b> , 19 <b>59</b> , to <b>Dec 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Dec 21</b> , 19 <b>59</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10609 Concord St. Kensington, Md.</b> DATE SIGNED <b>Dec 21, 1959</b> ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Alexandria, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of Colon

Division of Colon

Robert F. Thompson, M.D.  
1000 Locust St.  
Philadelphia, Pa.  
Dec 21, 1950

Robert F. Thompson, M.D.

15-24-50

Final

Robert F. Thompson, M.D.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13973

14002

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>9638 Dewmar Lane</b>				d. STREET ADDRESS <b>19638 DEWMAR LA.</b>			
3. NAME OF DECEASED (Type or print) <b>CHARLES ALBERT ZANNER</b>				4. DATE OF DEATH <b>DEC. 7 1959</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 21 1872</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JEWELER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRIVATE</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ZANNER</b>		14. MOTHER'S MAIDEN NAME <b>ALWINA WEISS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>A.W. ZANNER S.R. - SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>10 yrs.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypostatic Pulmonary Congestion</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 27, 1950</b> to <b>Dec 6, 1959</b> that I last saw the deceased alive on <b>Dec 2, 1959</b> and that death occurred at <b>5:15 a.m.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Luther H. Snyder</b> M.D.				ADDRESS (Street, city or town, state) <b>915 19th St. N.W.</b> DATE SIGNED <b>12/7/59</b>			
PHYSICIAN'S NAME (Type) <b>LUTHER H. SNYDER</b>				<b>Wash. 6, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J H Hines Co</b> ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>DEC 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 2a,b,c + Film G253 12/24/59 1wk

## CERTIFICATE OF DEATH

Reg. Dist. No.

13974

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X 2900 Peregow Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lydia G. C. Zing</b>		4. DATE OF DEATH <b>12 10 1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-83 ?</b>
9. AGE (In years last birthday) <b>76 1/2</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MORGAN WATERS</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WMJ. COE</b>	
17. INFORMANT <b>WMJ. COE</b>		Address <b>2900 PEREGOW DRIVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1957, to <b>Dec 10</b> , 1959, that I last saw the deceased alive on <b>Dec 9</b> , 1959, and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold W. Beeman</b>		DATE SIGNED <b>12/10/59</b>	
PHYSICIAN'S NAME (Type) <b>Kensington, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/14/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan</b>		ADDRESS <b>317 Pa. Ave S.E.</b>	
24a. REC'D BY REGISTRAR <b>DEC 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13975

Reg. Dist. No.

14004

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>3100 Brandywine St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Zirkin</u> Last <u>Zirkin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2.27.05</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>54</u> Days <u>54</u>	IF UNDER 24 HRS. Hours <u>54</u> Min. <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fire business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HYMAN ZIRKIN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Wife SAME AS ITEM 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4.20.1</u> DUE TO (c) <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGES CO. MD.</u> (MARYLAND)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u>				ADDRESS <u>1756 Pa. ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

